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Supreme Court, U.S.
FILED
OCT 26 2004
OFFICE OF THE CLERK

No. 04-5462

In The Supreme Court of the United States

RONALD ROMPILLA,

Petitioner,

v.

JEFFREY A. BEARD, Secretary,
Pennsylvania Department of Corrections,

Respondent.

On Writ Of Certiorari To The United States Court Of Appeals For The Third Circuit

JOINT APPENDIX
VOLUME V, PAGES 939 TO 1279

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Petition For Certiorari Filed July 23, 2004
Certiorari Granted September 28, 2004

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COURT OF COMMON PLEAS OF
LEHIGH COUNTY, PENNSYLVANIA
CIVIL DIVISION

COMMONWEALTH OF PENNSYLVANIA,	:	NO. 682/1988
Respondent	:	
vs.	:	
RONALD ROMPILLA,	:	
Petitioner	:	

DEPOSITION OF CAROL L. ARMSTRONG, Ph.D.

Taken in the offices of Slifer, Voice & Shade, 1228 Walnut Street, Allentown, Pennsylvania, on Tuesday, April 2, 1996, commencing at 1:00 p.m., before Sally A. Slifer, RMR, Registered Merit Reporter.

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[3] MR. WISEMAN: The record should reflect this is a deposition of Carol Armstrong, Ph.D., in regard to the post-conviction proceeding in Commonwealth versus Ron Rompilla.

The parties have previously agreed to make all objections on the record and not to reserve any objections.

CAROL L. ARMSTRONG, having been duly sworn, was examined and testified as follows:

* * *

DIRECT EXAMINATION ON QUALIFICATIONS

BY MR. WISEMAN:

Q. Dr. Armstrong, could you tell us what your occupation is?

A. Neuropsychologist.

Q. And whom are you employed by?

A. University of Pennsylvania Medical School.

Q. And can you tell us something about your educational background?

A. Well, I have a bachelor's degree in psychology from Vasssar [sic] College. I have a MA and a Ph.D. in psychology from the Wright Institute in Berkeley, California.

Then I did two post-operative [4] fellowships in the subspecialty of neuropsychology both in Ohio.

Q. And for how long have you been employed at the University of Pennsylvania?

A. For six years.

Q. Have you published in the area of neuropsychology?

A. Yes, I have.

Q. Approximately how many articles?

A. Ten or thirteen, something like that.

Q. Have you ever given any talks or presentations on neuropsychology to professional groups?

A. Yes. Quite a number.

Q. Can you just give us a sampling of who you have given such talks to?

A. I have given talks to international neuropsychology societies, neurology, professional organizations, head injury foundations, brain injury rehabilitation conferences, and trial lawyer seminars, probably covers most of them.

Q. And have you been qualified in the federal Court in Pennsylvania as an expert in neuropsychology?

A. Yes.

[5] MR. WISEMAN: At this time I would tender Dr. Armstrong as an expert in psychology and neuropsychology.

MR. McINTYRE: Subject to using her resume as an exhibit? You said that off the record before we had her resume.

MR. WISEMAN: I didn't say – I will ask her questions.

Q. When did you graduate from college, Doctor?

A. 1975.

Q. And from college you went where?

A. To the Wright Institute.

Q. And you got a Ph.D.?

A. Yes.

Q. In psychology?

A. Yes.

Q. When?

A. 1981.

Q. And after Wright – when did you get your Ph.D. there, what year?

A. 1981.

Q. Then what did you do?

A. Then I went to Ohio and did a post-doctoral fellowship at Western Reserve [6] Psychiatric Rehabilitation Hospital, and then another – then another one at – that was in Cleveland. Second one was at – for the Ohio Industrial Commission, Rehabilitation Division, in Columbus.

Q. When was that completed?

A. Those were both in neuropsychology. Let's see. Well, I think 1983.

Q. And when did you join the staff at the University of Pennsylvania?

A. That was in late '89.

Q. What did you do between '83 and '89?

A. I was chief of the neuropsychology lab, assistant director of psychology at Bryn Mawr Rehabilitation Hospital, which is a – actually award winning brain injury rehab hospital.

Q. For those six years?

A. Yes.

Q. Did there come a time when you began or have you ever begun testifying in the area of mitigation issues in capital cases?

A. I have done one previous capital case.

Q. What case was that?

A. Clifford Smith.

Q. Is that a Commonwealth of Pennsylvania [7] case, is that a Pennsylvania case?

A. It was a federal case.

MR. NOLAS: Do you want me to clarify.

A. I don't know if I can clarify that.

Q. Is that the case that was brought out on direct that you have been qualified as an expert?

A. Yes.

Q. That's a federal prosecution?

A. No, its not.

MR. McINTYRE: Clarify.

MR. NOLAS: Federal habeas corpus proceeding arising out of a Commonwealth of Pennsylvania conviction and death sentence.

Q. It is a Commonwealth of Pennsylvania case. And in that case, the defendant's name was what?

A. Clifford Smith.

Q. I take it he had been convicted?

A. Yes.

Q. And a petition was filed on his behalf?

A. Yes.

Q. Alleging ineffective assistance of counsel in the mitigation phase?

A. I don't think I can well represent how [8] it was presented and the issues that were presented. I would like to defer legal questions to the lawyers who were involved in that.

Q. Is that the only time you had been qualified as an expert?

A. Well, I think I probably have been qualified as a, medical expert in a number of other cases, both in Pennsylvania and probably – well, probably all in Pennsylvania.

Q. You had only mentioned one. That's why I am asking, were there other cases here in this Commonwealth you have been qualified as an expert?

A. Yes, I believe so.

Q. And – none other than this Clifford Smith case though on the issue of mitigating damages, I take it?

A. That's correct.

Q. In capital cases?

A. That's correct.

MR. McINTYRE: I have no problem. We will agree she can render an opinion.

MR. WISEMAN: Off the record I indicated to Mr. McIntyre we did not have a copy of Dr. Armstrong's CV. I will provide one and would like to have it preemptively marked, if we could, I [9] guess we are up to Exhibit 16.

(Defendant's Exhibit Number 16 was marked for identification.)

* * *

DIRECT EXAMINATION

BY MR. WISEMAN:

Q. Doctor, did you have occasion to evaluate Ronald Rompilla?

A. Yes, I did.

Q. And do you recall when that was?

A. It was on March 5th, 1996.

Q. Where did your evaluation take place?

A. At the state correctional facility at Greene, in Pennsylvania.

Q. And approximately how long did you spend with Mr. Rompilla on that occasion?

A. Must have been five hours.

Q. And in that five hours, did you do any type of testing?

A. Yes, I did. I did neuropsychological testing?

Q. Did you do any psychological testing?

A. What do – you are saying psychiatric testing.

Q. Psychological as opposed to [10] neuropsychological, straight psychological tests?

A. No, I didn't.

Q. Did you do anything with Mr. Rompilla on that occasion other than administer neuropsychological tests?

A. I interviewed him to get personal history.

Q. We'll get to your conclusions in a little bit, but would it be fair to say you reached some conclusions with regard to Mr. Rompilla?

A. Yes.

Q. And were those conclusions reached to a reasonable degree of psychological and neuropsychological certainty.

A. Yes.

MR. WISEMAN: Why don't we mark a copy of your report for the record. This would be Exhibit 17.

(Armstrong Deposition Exhibit Number 17 was marked for identification.)

Q. I want to talk, Doctor, about some of the testing that you did and the results and the conclusions that you drew from that testing.

In your report you have a category, sensory and motor functioning, what is [11] that?

A. That category includes tests of tactile perception and motor functions which are helpful in measuring specific brain regions, the behaviors of specific brain

regions as well as are sensitive to the presence of brain injury.

Q. Now, did Mr. Rompilla score an impaired range in any of that testing?

A. Yes, he was severely impaired in the test of manual praxis which basically means the, ability to coordinate and program motor movements, hand movements in this case.

Q. Now, what exactly did that test entail, what did you do in that test?

A. The items in the test were derived from a standardized battery that are used to measure dementia as well as brain injury, other type of brain injury.

The items are for hand movements that are done with both hands. Two of the movements involved movements of the hands in an alternate fashion. The other two also required alternate movements of the hands but more rapid.

For example one of them involved tapping twice with one finger and once with the [12] other and repeating that pattern. (Indicating.)

He had quite a bit of difficulty on that, an unusual degree of difficulty certainly – well, frankly in anyone of any age, even older people do not make many errors on that test. One side tended to fail to make a movement when it was supposed to in the sequence.

There are also impairments – he was unable to achieve the correct position of the hand even though I would bring it to his attention, see that he could do it, but

then when we he would carry out the movement he would revert back to the incorrect position.

He also would make what we call perseverations, if you are supposed to tap two times, if there's discontrol in a motor area of the brain, an extra tap will come out. That's called perseveration. You can't stop yourself from a behavior or a movement. So those are the types of errors – he made all those types of errors. Those are the three main categories of errors you can make. His right side was worse than his left at least on that test.

Q. What does severe impairment on that particular test tell you about Mr. Rompilla's brain?

[13] A. Well, it suggests impairment probably in – the test measures impairment of the frontal parietal areas, both of them are involved in movement control.

The parietal area is involved in spatial and visual control of movement and the frontal directly controls movement.

I would say by the nature of errors that he made there is probably evidence of both areas being injured or damaged.

Q. If we could go down to the section of your report that deals with attention, what is the significance of attention in your evaluation?

A. I'm sorry, why did I give him attention tests?

Q. Why do you give people attention tests?

A. Attention is thought to be primarily again controlled by the parietal lobe, also by the frontal lobe once again.

We look for medulla effects. That means how well the person is able to attend to visual information versus auditory information. And how well they are able to sustain their attention and things like that.

And in one test of visual [14] selective attention, selective simply refers to an automatic process, that means it doesn't involve a lot of effort or shouldn't – doesn't involve effort.

A process of selecting a target on a piece of paper in front of the person, a piece of paper only 8 and a half by 11 piece, not a very large piece and he has to scan and find the belts on it.

And he, you know, according to the published norms on that test, he missed too many of the targets. There's an example of him looking at his environment and not being able to automatically identify what he's looking for.

The problem on the reversal tests can be thought of –

Q. Reversal of verbal patterns and visuospatial patterns?

A. That's where you are given a series of numbers spoken to you where you watch some pointing movements and then you have to perform those digits or pointing movements in the backwards order. That backwards order is thought to tap spatial properties as well as memory. Because you have to hold the stimuli in order to create spatial pattern to [15] reverse it from.

So again, as I said, that would involve both memory and some kind – it involves sustained attention.

Q. And how did Mr. Rompilla score on the visual selective attention test?

A. Mildly impaired.

Q. On the reversal of verbal patterns?

A. Mildly impaired.

Q. Reversal of Visuospatial Patterns?

A. Moderately impaired.

Q. Is moderately more or less than mildly?

A. Moderate is more. I use the nomenclature average, low average, borderline, mildly impaired, moderately impaired, and severely impaired.

Q. Your report also has a section on language. What is the purpose of testing for language?

A. To look at basic functions of the ability to understand words, understand sentence structures, to read words, to write one's thoughts and retrieve words for writing.

Then the fluency tests are a kind of language production test in that you have to [16] produce language under different conditions within a restricted period of time. So it's – the main functions – main neurological ways of testing language are being able to understand and express language.

Q. Now, did you administer a particular auditory encoding of syntax and grammar test?

A. Yes. That's called the token test.

Q. And what does that entail?

A. That entails putting in front of the individual tokens. These are little plastic pieces in the shapes of circles and squares. There are large circles, small circles, large squares, small squares. They are of five different colors.

Then the individual has to listen to a sentence that I state to him and perform what I said. He has to do what I say.

The questions are as simple as pick up the red circle or point to the two green squares, and the most complicated is pick up the red circle and – I'm sorry, touch the red circle with the green square, because there is implied syntax there that individuals sometimes have difficulty with.

That's the type of error he made, [17] being able to interpret syntax. It's not specific to a particular type of brain injury, but I thought it was notable.

Q. Did he – I notice in your report you don't have a conclusion as to what his score was on that test. Is there a reason for that. You just felt errors were made?

A. Yes. The full items weren't administered. I couldn't yield a score.

Q. Did you give him a reading and word recognition test?

A. Yes. I gave him a reading test, yes.

Q. And how did he perform on that?

A. He performed at the ninth percentile which is equivalent to the beginning of seventh grade.

Q. And what does that tell you about Mr. Rompilla?

A. It demonstrated his difficulty in recognizing whole words.

Q. He has problems reading?

A. Yes, he had difficulties – reading is done in various ways and what I could identify – it's not a problem of him understanding the sounds of the words, but in terms of recognizing what they [18] look liked [sic], his problem was at that level.

Q. In written expression – withdrawn. You administered a written expression test. How did he do on that?

A. He was quite impaired on that. I would consider it significantly abnormal. He left out grammatical terms in the sentence – I would have to – or I could give you an example of the type of error he made. If he would say, I want to go to the store, he would say – he might say, I want go the store. Something like that, where he would leave out important points of grammar.

He also made errors in selecting letters, those are allographic letters, letter images, and he also wrote in a spatially strange way, in terms of the shapes of the letters, in terms, of repeating certain forms of the letters.

This sounds highly detailed but this is how we go about analyzing language from a neurologic perspective.

So it allows me to be specific about whether the behavior being shown are errors that many people make because after all normal people make errors when writing as well. It helps me to sort out what's a normal type of error from [19] what's an abnormal error.

Q. Abnormal you mean one with neurological indications?

A. Yes.

Q. There's another category in the report, verbal learning and memory, what's the purpose of administering that battery?

A. The purpose of that, that's a test that gives me a lot of information about a person's memory. It allows me to see how well they are able to encode information into their permanent storage. How well they are then able to retrieve it from that storage. Whether they are able to improve the learning, if they are giving repeated presentations of something, as well as how well they are able to discriminate what they do have in storage.

He was impaired in various aspects of that test, to the point of getting a score at the first percentile which is – gets the rating of severely impaired.

Q. Let's take each of the batteries individually that he scored in the impaired range.

First let's start with the semantic sequential working memory span, how did he score on that test?

[20] A. Borderline – borderline impaired.

Q. What does that test entail, what do you do?

A. That involves repeating backwards in the same way you hear them. The normal span is five words. That's a fairly reliable performance by normal people. He never achieved five words. He was usually unable to consistently achieve four words.

Q. Semantic associative memory test, what is that test and how did he score?

A. He was severely impaired on that test.

Q. What does that test do?

A. The nature of that test is a learning task. The individual is given a list of known words, familiar words, fifteen. They have to try to recall them in any order.

They are given the list five separate times with recall given after each presentation. They are given a list of 15 separate words, to simply distract them from the previous learning so there isn't anything still being rehearsed.

Then they are asked to retrieve the first list again. There you have measures of [21] retrieval only.

Then there's a recognition portion to the test in which the target words are mixed in with the distracter words, that extra list, as well as words that sound similar to the target as well as words similar in meaning to the targets. These words, the words – distracter words which they just previously heard, the semantically related, sound related words are all called foils, attempts to confuse our memory.

Q. And how did he score on that test?

A. He was severely impaired.

Q. What percentile?

A. First percentile. He was impaired in how well he could learn and code the words. He had lots of intrusions which are considered highly abnormal. He was unable to benefit from the repeated presentations. He did not learn more as he heard it each time. He was impaired in retrieving

the words and he was impaired in discriminating them from the foils.

Q. Now, from a neurological perspective, what significance is there that he was in the first percentile in this test, what does that tell you about Mr. Rompilla's brain?

[22] A. I have done a number of research studies on this test, which is one reason why I use it, one reason why I am speaking a lot about it.

I have published also on it, and I know exactly what's a normal and abnormal pattern on it.

What's abnormal are the things that I have mentioned. It means that he's – when he's listening to information in the environment, he's not getting a normal amount of it into his memory.

It means that what he does have – in memory he's not able to retrieve accurately or normally. That is he can't retrieve enough of it. What he's retrieving is also marked by confused information, unrelated information.

And even when you make the task easy for him, which is to just let him recognize whether he heard the word or not, he still continues to be unable to recognize the word accurately and he mixes it up with unrelated information.

You can see how that would be functionally problematic for someone who needed to rely on their memory. They are not going to recall things accurately – They are going to be confused [23] about it, and they are not going to learn new information very well.

Q. The next test you have listed is retrieval after interference. Could you explain what that is about?

A. That's part of the test I described. I break out the different components. Semantic associative memory, retrieval after interference, retrieval after delay, and recognition memory are all indices from that test.

Q. And how did he score on the retrieval after interference?

A. He was severely impaired.

Q. What percentile?

A. At the first percentile.

Q. And in recognition memory how did he score?

A. If I may back up, the negative recency problem that he demonstrated, without going through a big explanation, and I have associated it with frontal lobe dysfunction. The frontal lobe has a special role in measuring – I'm sorry, in guiding our behavior to be done in a certain time. It has to do with time.

That negative recency reflects a [24] problem with time coding. The retrieval after delay was normal. That means that what he has learned doesn't deteriorate over time.

He may not retrieve it for other reasons, not just because of forgetting. Then recognition memory was severely impaired in his case as well. He was unable to separate the target words from the distracting words.

Q. The next group of tests are the visuospatial processing and memory, what exactly are they designed to measure?

A. Various aspects of visual perception, spatial perception, integration of perception, and aspects of visual and spatial memory.

Q. Why is that something you measure in a patient?

A. There are known – fairly known relationships between general brain regions and these various tests, certainly because brain regions and types of visuospatial perception. It's an important area to examine as it's impaired in a number of neurological diseases as well as gives you some insight into how a person's functioning within their environment, whether they are likely to be oriented, you know, find their way around, get lost, [25] remember what they see and so on.

Q. How did he score in the facial perception test?

A. He was mildly impaired on that.

Q. What was the percentile?

A. Eighth percentile.

Q. On the mental spatial rotation test?

A. He was severely impaired on that in the first percentile.

Q. The last grouping you have is intellectual processes, what's the importance of measuring those?

A. It's – these are measures of problem solving.

Q. In particular, logical deductive reasoning tests of that group, what does that measure?

A. That measures the ability to create a conceptual understanding of something; to be able to switch from one conceptual understanding to another conceptual understanding.

It reflecting the ability to use information from the environment to guide your behavior. It also reflects the ability to hold information in mind while you are reasoning, and [26] it's been well associated with the frontal lobes, and I have also published on that.

Q. Now, the cognitive flexibility and written calculation test, he scored in the borderline range?

A. Yes.

Q. What do those measures?

A. Cognitive flexibility is another index from the – what's called here the logical deductive reasoning test. That reflects whether a person continues to answer something in the same way, even though they are being told that's incorrect.

Or whether they are able then to take that information and look at a problem in a new way. So he was borderline impaired on that. The written calculation is just what it sounds like, it's working out arithmetic problems.

Q. Based on the testing you gave to Mr. Rompilla, did you reach any conclusion to a reasonable degree of neuropsychological certainty as to whether or not he has any organic brain impairments?

A. Yes. In his case it's not just a matter of a number of severely impaired scores, it was the nature of errors he made that made it very clear to [27] me there was organic brain injury involved and the cognitive deficits were basically all of the domains that I tested, almost all the domains I tested, they were in control of movement, in attention, memory, reasoning and in visuospatial perception.

Q. Now, did you draw any conclusions as to the presence or absence of learning disability in Mr. Rompilla?

A. Well, the quality of his reading and of course the low score, also the low score in arithmetic, was suggestive of a learning disability problem, because you rely on your previously stored abilities to perform those tests, they are just achievement tests. That's one pretty good indication right there.

Q. Indication of?

A. Of learning disability. There's also his explanation to me of his – how he was called a dummy as child, that – there's not a lot he remembers about his childhood. He remembers, he says, nothing about his early childhood.

I was unable to gather any more information about his early learning history. He remembers being called a dummy. That is something that is salient for him.

[28] I took that as a red flag that that probably characterized his childhood; that he behaved as a dummy; that people saw him as being incompetent.

And he also didn't perform well in school according to him and didn't go very far through school and never had any work that was beyond semiskilled by my estimation.

These are all – this lack of achievement is often underlied by limited capacity.

Q. Is learning disability a function of brain damage?

A. Learning disability is thought to reflect developmental damage, so it is usually the result of neurological damage at some point in development.

Q. When you say development, what do you mean, childhood development or –

A. Well, the damage in development can occur anytime from the fist [sic] trimester of embryo development to early childhood.

Q. Just in terms of years, where is the cut off for early childhood?

A. Well, I guess frankly if you're going to talk about injuries that can affect development, you [29] would have to extend that from beyond early childhood to adolescence as the brain doesn't actually mature until the 20's.

Q. Did you reach any conclusions as to whether or not the testing you gave Mr. Rompilla was valid?

A. Yes, I also included a test, a widely – I shouldn't say widely used but a well accepted test called the symptom validity test which means that you present the individual with a learning task that is so easy that virtually all normal individuals will do well on it.

But you present it in a way that suggests, you know, maybe it isn't so easy and you will understand if he has a problem on it. It looks like a lot of information. But it's inherently organized, which makes it very easy to learn.

He performed normally on that. I also had no other evidence from watching him take the test and seeing the results to think that he was not responding in a valid way.

Q. In a number of the tests you administered he scored in the normal limits and scored average or high average.

What does that tell you about the [30] validity of the test?

A. It tells me he wasn't deflating his scores or his performance across the board; that he has the capacity to do well and was showing me that capacity in some areas. It shows that – I think I have said it.

Q. The test that you administered to Mr. Rompilla – withdrawn.

Neurological and neuropsychological evaluations, for how long historically have they been available to the mental health practitioners?

A. Neuropsychological evaluations I will say – neurological evaluation of behavior is hundreds of years old. Much it became very popular in the 19th century and before that time.

Neuropsychological evaluations, battery of tests, began – beginning after World War I but really took off after World War II because there were so many solders [sic] that came home with head injuries, and the batteries that used to be in primary use, Halstead-Reitan and Luria Nebraska, neuropsychological batteries were both developed during that time, the '40's.

Q. The testing you gave to Mr. Rompilla, [31] was it available and widely used in 1988?

A. Yes. Those tests were developed in the '60's and '70's, of the 20th century.

Q. Did you reach any conclusions based on your testing as to whether the impairments Mr. Rompilla has affected his impulse controls or impulsivity, if you will?

A. I think that the impairments he showed were demonstrated most in the area of reasoning; not – not directly in the area of impulse control. That's not to say that I disproved impulse control but I don't think that was what the testing was telling of.

I think they most demonstrate reasoning difficulty and inability to respond appropriately to the environment and to think something through in just a reasonable fashion.

Q. Obviously the tests that you have – that's called logical deductive reasoning, I take it measures reasoning ability. Were there other tests that also measure reasoning and – that measure reasoning?

A. Arithmetic test measures reasoning. I mean, it depends on what you mean by reasoning. If you mean being able to put your thoughts into [32] language, there's some other measures I gave him that I didn't describe in the report that also measure reasoning, that he – perhaps I could use an example from it.

When asking the individual questions, the answer to which are people don't know, you can sample any group of people and they won't know them. For example – I'm sorry, and so you have to make a guess. Basically you want to

see if the guesses are appropriate, whether they are guesses that most people would make, and you can see something more. You can also see whether there are some logical inconsistencies to the answers they gave. That's where his problem lay.

When asked how tall is the tallest building he gave reasonable answers. He said 200 stories. When asked how tall is the tallest mountain in the world, he estimated it was a little bit taller than the building, 300 stories. That's an illogical kind of answer to give.

When asked how long is a man's spine, you know, when you don't know how long a spine is but you make a reasonable guess as to how long the spine is in relation to the whole length of the man, for example, only the legs are not part [33] of – you know, are not part of the length of a spine, and his best guess is that the spine was one foot long.

I know from research in this area, from having read research in this area, that those answers are in the severely impaired range. Those are some examples of a reasoning problem he has.

On the logical deductive reasoning test, his problems were that if he did get – the test is actually not difficult at all. It's very easy. Even old people do well on the test. It's not influenced by depression. It's a test that a normal brain should be able to do.

He – in the test you are given cards, four cards, four master cards, that have four different colors – I'm sorry each card may be one of four colors, each card may have on it one of four shapes, and there may be anywhere from one to four of the shapes on the card.

Then you take another set of cards and you have to match them either to the color or to shape or to number now. If he ever chanced upon or got an idea as to how a card would match and I would tell him, yes, that's correct, even if he got it correct two or three times, he would forget it.

[34] So he – can you could think, telling himself, all right, I understand, it's color now, let me match it by color. Do it two or three times and then he will start doing something else. That's what unable to maintain mental set means. He's unable to keep that train of thought.

He has a big problem with distracters as showed up on the memory test all over the place. So his thoughts are constantly being interrupted and he's not able, I believe, to follow a train of thought which is necessary to solve problems. To solve a problem you have to hold one thought to connect it with another thought. That's why I say what I think is mostly evident from these tests are in his inability to think, to solve a problem, to make accurate estimations, to hold a thought, to have memory long enough to hold a thought, to not be confused by other distracters.

Q. Do his deficits in those areas also impact upon judgment?

A. They necessarily impact upon judgment because he would be making judgments with basically invalid information or incomplete information because he wouldn't remember it.

Q. Do his deficits in this area impact upon [35] his ability to measure the future consequences of his behavior?

A. Yes, it would, because he's unable to integrate feedback. He's unable to adjust what he's doing based on the information he's getting from the environment. He's unable to make a plan that would take into account, you know, if you have a problem thinking through something, that then you are not going to get to the point of knowing the consequences of something. You will not have thought that far through it.

I am certain he wouldn't be able to think of all the implications of an action. He'd [sic] probably did act based on what was just immediately apparent, which based on his cognitive impairments might change from moment to moment.

Q. I take it from that answer you determined he had cognitive impairments?

A. Yes.

Q. Do the impairments you just described have an impact on his ability to control his behavior?

A. I only tested his cognitive behavior. The impairments he demonstrated certainly affected his cognitive behavior. If I can interject, if it's [36] relevant, if it's not that's fine. He also demonstrated – he told me about an incident where in prison, where he lost his temper while playing cards with someone, and seemed to have no thought process that would have intervened between punching the guy out which caused him, I forgot how many days in solitary, I think he said two months in solitary confinement, and, you know, over some scuffle over cards.

When I asked him – well, I didn't actually inquire a lot. But I listened to what had happened, and he, you

know, didn't have any thought process that he went through that might have, you know, given him a reason to stop himself.

So I think there's a pretty good example of an impulse control problem and functioning and behaving based on what's immediately in front of you and not in terms of consequences.

Q. Your conclusions that Mr. Rompilla suffers from the organic impairments you described, was that based on your testing or was it based on what he told you about punching someone out?

A. It was based on the test patterns, the test scores and the test patterns.

Q. Do the organic impairments you described [37] have any impact on his emotional lability?

A. On his emotional lability?

Q. In the sense –

A. Yes, in the sense that his reasoning is impaired.

Q. Explain that, when you say in the sense?

A. We all function with the same primitive brain to motivate us. The part of the brain that motivates us, and drives us and gives us emotion is the oldest part of the brain that's present in all mammals. Of course some components are present in lizards too but to stick with the parts we are more familiar with, the motivational aspect is present in all mammals.

That means it requires a more advanced part of the brain to control it. That is we have developed more

monitoring, reasoning capacities than other mammals do. We use them to control our emotions because we live in a very crowded society with – under many stressful conditions that cause us to feel emotional. And we use our cognitive abilities to control and monitor and mediate that emotion.

Cognitive abilities are very important for all components in a person's life; [38] their social behaviors, their family behaviors, certainly their emotional behaviors, their work behaviors, even their recreational behaviors are affected by their cognitive abilities. Does that answer your question?

Q. Yes. I believe so. Thanks.

I want to ask you about some conclusions that you may have reached with regard to your testing, just your testing. I am not interested in other collateral information you may have used.

Based on your testing, does Mr. Rompilla suffer from organic brain damage. Assume I am asking these to a reasonable degree of neuropsychological certainty.

A. Yes. I strongly believe that these results are not the product of – how do I – well, I don't believe they are the product of poor motivation. He's very motivated.

I don't believe they are the product of faking of any kind. I have evidence of that. They are not the product of poor education, because many of these tests are not tests of education ability.

Q. Not achievement tests?

[39] A. No. And they don't correlate with education. I have done research on this. They don't correlate with education.

They are tests of the – how well different parts of the brain are communicating with each other. And I strongly believe again, not just on scores that are low, but on the types of errors he made, and due to his impairment on some scores that are only – some ability is only impaired when there's brain injury, such as the manual praxis, that taken together all his performances there's a very clear picture of brain damage.

Q. By the way, I am not sure I heard the answer, you said there was no evidence of faking or evidence of faking?

A. I have evidence there was no faking.

Q. Let's put it in the affirmative. Was there evidence of faking?

A. There was no evidence of faking.

Q. Did you reach a conclusion as to whether or not Mr. Rompilla suffers from a learning disability?

A. Yes, I think that he probably does suffer from a learning disability.

Q. Did you reach a conclusion as to whether [40] he's suffered from this organic – these organic deficits in 1988?

A. Based on my knowledge of his history, these deficits were in all likelihood there in '88.

Q. Could you date the deficits to childhood to a reasonable degree of neuropsychology [sic] certainty?

A. Yes, based on the pattern of deficits and his history, I would date some of the deficits at least to childhood.

Q. Now again based just on your testing, at the time of the commission of the offense in 1988 was Mr. Rompilla under the influence of an extreme mental or emotional disturbance?

A. The emotional – extreme mental emotional disturbance is neurological brain damage and cognitive impairment, yes, he did have that.

Q. Do you consider them to be an extreme mental emotional disturbance?

A. Yes, I do.

Q. At the time of his arrest in 1988 was Mr. Rompilla's capacity to appreciate criminality of his conduct or to conform his conduct to the requirement of law, substantially impaired?

A. Yes.

Q. That's based on your testing?

[41] A. Yes, it is.

Q. Now I would like to put your testing aside for a while. Did you review other materials provided by counsel in regard to Mr. Rompilla?

A. Yes.

Q. Did you review school records from his elementary school?

A. Yes.

Q. For the record, these records have been previously marked. The school records were marked before the Judge as Defendant's 8. I want to put in front of you school records related to Mr. Rompilla and direct your attention to the Wechsler Intelligence Scale for Children test that was administered in October '59.

What was his score in that test?

A. In October of '59 it was 64.

Q. That's a full scale?

A. Yes, that's the full scale IQ.

Q. And 64 is what you said?

A. Falls into the mildly mentally retarded range.

Q. And before that, there's a partial test that was administered, partial WISC, verbal portion in April of '57?

[42] A. Yes.

Q. He scored a 75?

A. Which is borderline mentally retarded range.

Q. In December of '61 there's another WISC that was administered?

A. Yes.

Q. How did he score in that?

A. 69 which is below that 70 cut off for mental retardation. Once you get a score in that range, the state – you become eligible for mental retardation services so it's a formal cut off.

Q. In June of '61 there's a standard achievment [sic] test administered?

A. Yes.

Q. Do you see the results of that test?

A. Yes.

Q. How did he score on that?

A. His performances were largely at the third grade level, and, let's see, in '61 he was thirteen years old, which would put him at about the seventh grade. That's very significantly below what he should have achieved at that time.

Q. I identified the WISC as the Wechsler intelligence scale for children. What is that?

[43] A. It's a set of eleven or twelve tests based on the idea that intelligence is not one capacity, such as reasoning, but made up of many different mental capacities.

It's the best intelligence test and most widely used intelligence test used today. Only intelligence test used by schools. It's the test they use to identify learning disability.

Q. How do his scores on these intelligence tests and on the achievement tests either support or refute your conclusions regarding his organicity?

A. They certainly supported my suspicion he had a learning disability and what it does is in my report I indicated that if the learning disability could be documented in childhood it may be that even more of his deficits are due to that. Because the most prominent, let's

say, source from what we know about him of learning disability is his mother's drinking while she carried him.

Now, drinking during pregnancy is very dangerous to the fetus. Often causes mental retardation. Now, whether he's showing chronicity or not, the pattern of dyslexia, nonlearning versus learning disability or any specific learning disability he shows a generalized problem to the [44] point of being basically retarded.

I think that says that in fact his – the deficits I find today, you know, a good number of them let's say may have been present from childhood, or at least from seventh grade, if not earlier.

Q. Leaving aside for a moment the potential causes for the learning disability and/organicity, the question I have is do the test scores from his elementary school support your finding of organicity?

A. Yes, they do.

Q. If you see a patient with the scores in the mental retardation range, is that a red flag for you there may be organicity in the case?

A. Mental retardation is organicity.

Q. I guess it's a red flag then?

A. Yes.

Q. The record indicates that Mr. Rompilla was in – after grade three placed in the SP class. Assuming that means special ed., does his placement in special ed. support your findings on the testing of organicity?

A. Yes.

Q. Why?

[45] A. Because only childrens [sic] with significant, learning disability are placed into that – are taken out of the main stream classroom and given a lower level of educational stimulation because that's all they can handle and because they are supposedly trying to help them gain some basic academic abilities like reading and writing even though it may not be successful. It means that the impairments in reading, writing and arithmetic that I found, whether they were also existent back when he was in school.

Q. If you looked at the grades that Mr. Rompilla appeared to achieve, grades seven, eight, and ninth which for the most part seem to be passing grades, do they add to or take away from your conclusion there was organicity based on your testing?

A. No, it doesn't take away from the organicity picture. He was in special ed., and special ed. doesn't mean that – the child gets graded in relation to other children in special ed., not in relation to the main stream group. These scores of 75 for example or 70, scores are almost all in the 70's –

Q. Let's assume he wasn't in special ed. [46] Let's assume he was in regular classes then.

A. I don't think he achieved those scores in regular class. I don't think he could.

Q. Based on your testing?

A. Based on my testing and these – this information. these IQ's.

Q. IQ tests, are they standardized?

A. Yes, they are standardized among children.

Q. Are grades in schools standardized?

A. Not on a larger population norm. They are only – national test scores are, but if you just mean the grade in the classroom, no, that's based on the teacher's view of that class. Local norms let's call it.

Q. Did you have a chance to review some test data from approximately 1975, from the Department of Corrections?

A. I believe I did.

Q. Let me put an exhibit in front of you. For the record that's Exhibit 7 that's been marked before the Judge. Directing your attention to the wide range achievement test scores, 32nd percentile in reading, fourth percentile in spelling, third percentile in arithmetic; what does that either add [47] to or detract from your conclusion of organicity?

A. It's pretty consistent with my test scores. He was in the average range in reading at that time. While we both used the wide range achievement test, they used – this psychologist used an earlier version of it and so there could be some difference in the norms that existed.

But the overall picture is of someone who has probable – possible learning disability or retardation, depending on what their IQ measured as.

In other words, is there some specific learning problem just in perhaps spelling or arithmetic or is there more

generalized cognitive impairment or did the person fail to learn how to spell and do arithmetic because they were never exposed to spelling and arithmetic. That's a third explanation.

But he did go through school. He did receive special ed. They did give extra attention to his reading and arithmetic abilities. You have to exclude the possibility it's based on no exposure to reading and arithmetic. You have to go back to the other ideas, that he has a special learning disability, a particular learning [48] disability, or he has widespread mental problem – problems with his mental capacity.

Q. Again, if you were to review a WRAT score such as the one Mr. Rompilla had in '75 would that raise any red flags for you as an evaluator as to organicity or learning disabilities?

A. It would raise red flags.

Q. And would you explore that further?

A. Oh, yes, I would.

Q. Have you had occasion to review a medical record of Mr. Rompilla at the age of two? For the record that is Defendant's 9.

A. I believe I have.

Q. Directing your attention to the entry when he was age two?

A. Yes.

Q. What does that record indicate that his condition was when he was admitted to the hospital on that occasion?

A. Diarrhea due to undetermined cause.

Q. Does it say anything about fever?

A. His temperature was 105 degrees, I presume that's Fahrenheit.

Q Taking the factors that he had a hospital admission based on diarrhea and a fever of [49] 105, do those facts add to or detract from your testing conclusion that he suffers from organicity and a learning disability?

A. Would you repeat that?

Q. Sure. Are these facts, regarding this hospital admission, consistent with and supportive of your conclusions from your testing that he has organic brain damage and a learning disability?

A. I don't know whether this condition caused his problems or not. It would not be inconsistent with it but it's a health problem of undetermined cause with a high degree of fever that can cause brain injury in a young child. But I don't have a lot of information here.

Q. Assuming that the diarrhea was of some duration, can diarrhea and dehydration lead to any problems in the development of a child?

MR. McINTYRE: Note my objection. I don't think there's evidence of any duration of diarrhea.

A. Prolonged high fevers or repeated high fevers can cause electrical and chemical imbalances in the brain and

can lead to seizure disorder. Dehydration can cause metabolic disturbances that can lead to brain injury.

[50] Q. Did you have occasion to review declarations signed by members of Mr. Rompilla's family?

A. Yes, I did.

Q. Do the assertions contained in those declarations portray a clinically significant profile to a psychiatrist?

A. Yes.

Q. Significant in what way?

A. Significant in terms of the indications of physical child abuse as well as the maternal drinking during pregnancy.

Q. Let's take them separately. Why is the abuse significant to a psychologist?

A. Well, to a psychologist – depends on what the psychological issue is. Are you asking specifically neuropsychologically?

Q. Yes.

A. Okay. The abuse is significant neuropsychologically, one, because you need to know how severe the abuse was and whether there could have been blows to the head or shaking of the child, both of which cause a very high rate of brain injury, very high rate.

There's a secondary, for my [51] purposes anyway, a secondary importance reflects on how the person then views themselves in terms of their self-confidence and how likely they are going to overcome problems in the future. That kind of behavior toward a child permanently injures

their concept of themselves and permanently detracts from their ability to resolve problems in the future and leads to, I would say, depression.

Q. Now, from a neuropsychological perspective, is what you are saying the abuse leads to a potential origin for the organicity?

A. It's a potential origin for the organicity.

Q. Again, if you were evaluating a patient and you saw abuse like that contained in the affidavits that you reviewed, would that raise a red flag for potential organicity?

A. Yes.

Q Did you draw any conclusions with regard to head injury as a potential explanation for Mr. Rompilla's organicity?

A. He had one incident – he's had a few times that he's had serious blows to his head but one time resulted in loss of consciousness which brings up a good possibility of there being at least [52] a concussion and possible more severe brain injury. And that was when children playing, I don't remember - well, I have it in my report. Let me check his age.

MR. McINTYRE: Twelve.

A. Thank you. He was twelve, the cliff, the rock –

MR. McINTYRE: Yes.

A. Anyway, children somehow at the age of twelve threw – I don't know how old the person was that threw the rock, but threw a large rock on to him from the cliff,

hit his left eyebrow and right lip. He showed me the scar he still had.

The first thing he remembers after that accident is his brother apparently carrying him either to the hospital or home. I am not sure at the moment.

Q. Did you have occasion to notice the scar before he pointed it out to you?

A. No. Frankly I don't do a physical exam, a visual physical exam.

Q. Why is that?

A. Because I am focusing on the cognitive processes.

Q. Testing?

[53] A. Yes. I am focusing on what they are saying to me and how they are reacting and behaving.

Q. Did the collateral information you reviewed, and by that I mean the school records, IQ testing, the Department of Corrections, wide range achievement testing, the family declarations, and the medical record that you reviewed; do they – are they supportive of your conclusion that the organicity is of longstanding and dating back to early childhood?

A. I think they do, yes.

Q. Could you elaborate on that?

A. There's nothing inconsistent with all of these points of data. There's evidence of learning disabilities so severe to represent mental retardation on multiple IQ tests. It's not like it was found once. It was found multiple times at different ages. So there's evidence of mental

retardation, early on, carry – carried out or I should say manifest his problems in schools such that he couldn't be mainstreamed in class.

He's very dissatisfied with school. He doesn't remain in school after the ninth grade. He never achieves a high level of education. All of this is consistent with limited capacity, [54] cognitive reasons.

I understand both his parents drink. And there is family report that his mother drank while she carried him. As I said before, that's a very, very serious – it yields – it's damaging to the infant, and the degree of damage is going to depend on how much drinking occurred but alcohol to a fetus is damaging.

Then there's his performance at this point in time demonstrating the learning disability and other cognitive impairments in reasoning, and memory. People with mental retardation are impaired in reasoning and memory consistently a hundred percent, part of the definition of their dementia.

They also have other cognitive impairments. He has them in cross domains, the fact he has impairment in cross domains indicating broad range impairment that is severe in some areas, mind you, he wasn't – all right, I have tested more severely retarded individuals and they have more severe scores across cognitive domains.

This fits the picture quite well. He has a learning disability. He is not a hundred percent severe impairment but that he didn't have [55] severe mental retardation documented early. He has mild mental retardation, considered more correct is educably retarded, which he was, and his vocational achievement level fits that.

I would say that my test results fit that by demonstrating, you know, impairment across all cognitive areas.

Q. The last area I wanted to talk to you about just briefly was Mr. Rompilla's use of alcohol throughout his life. Why don't you tell me about that.

A. I'm sorry, what did –

Q. What did he tell you about that?

A. He told me that he first began sneaking drinks around at the age of 15 to 16 because his uncle owned a bar, and he spent a lot of time there. It was available.

That at about the age of 17 he began drinking – he began bingeing, that is drinking wine until he passed out. That became his pattern; that whenever he drank, he drank until I suppose he couldn't drink any more.

He stated before 1988 when he was in, I guess it would have been, county jail, I can't remember whether it was county jail or state prison, [56] he would be able to access – well, they would make wine there. He's even drank when he was in prison.

So that adds up to a significant amount of drinking.

Q. Is there any significance as a cognitive factor of his organicity that he drank to that degree?

A. Yes. The effects of alcohol are defined by how much, how often, and how frequently – I'm sorry, how much, how frequently, and over what period of time the drinking occurred.

How much is very high. He drank a lot. How often, we have here at least three times a week at the age of 17 and

probably more after that. And then for how long, from the age of 17 to about the age of 40 he would drink whenever he could.

Then there's the idea that in neuropsychological testing, the effects – the damaging effects, the evidence of alcohol having damaged the brain is usually not seen until about the person's forties. Well, that's also the age that he was in when I saw him.

So there is – then there's the nature of the abnormal performances he gave me, a number of which were consistent with brain injury [57] due to alcohol. That becomes another potential etiology or cause for his cognitive impairments. But as I say, with his – well, I think I probably answered your question.

Q. Last question I wanted to ask you about alcohol was does alcohol consumption exacerbate the effects of the organic impairments Mr. Rompilla has?

A. Yes, there is research to support that definitely.

MR. WISEMAN: I have nothing further. Thank you.

* * *

CROSS-EXAMINATION

BY MR. McINTYRE:

Q. Dr. Armstrong, just a few questions. Your report of March 15th, 1996, you have a part on page three called background information?

A. What date?

Q. March 5th. On this page it says March 15. The first page says date of testing March 5th?

A. The report is typed March 15th.

Q. On page three, background information,

A. Yes.

Q. That was all gotten from Mr. Rompilla?

A. No, also statements from family [58] members.

Q. Just so that I am clear, at the time you did this report, did you have all the other information which Attorney Wiseman asked you about today?

A. No.

Q. What did you have, did you have the declaration of family members?

A. I had that. I did not have – I had the 1975 – I had had the 1975.

Q. Prison records?

A. Records, yes, and from the testing done then. I didn't have any of the testing done during school. And I had a statement by – of the 1988 testing.

Q. 1988 testing?

A. Yes. I didn't have the testing itself, I only had a statement with it. I didn't have it in any detail.

Q. This statement here, other review of his history reveals his mother drank probably during pregnancy with him?

A. Right.

Q. That is what you got from the family declarations?

[59] A. What I got from the family declaration is she drank during pregnancy. It's my conservatism to say she probably drank during pregnancy.

Q. Do you know from what sibling or family member you got the information?

A. If I could look at the records of course I could tell you. I remember two, one was a brother and one was the wife of the brother.

Q. A brother and a wife of a brother?

A. Yes.

Q. Do you know how old the brother was when the mom was pregnant with Ronald Rompilla?

A. I don't recall.

Q. Did you ever attempt to verify that information by obtaining the mother's records for hospitalizations –

A. No.

Q. – in regard to her pregnancy?

A. No, I didn't.

Q. How about the information you have in your report about the episodes when he had alleged head injuries, did you ever attempt to verify that with hospital records?

A. Well, I would say, yes, because I always ask for these records.

[60] Q. You attempted?

A. Attempt becomes valid.

Q. Did you succeed?

A. No.

Q. Do you know of any hospital records that support any type of head trauma?

A. No, but I don't know whether he went to the hospital then or not.

Q. If he had some type of head injury, it wasn't serious enough that it resulted in a hospitalization?

A. No. You can't conclude that. Even today, but certainly back at that time, children's head injuries were not considered to be important. People were just – first of all, his family may not have been the kind to care for their children very well. They may not even, for all I know, have known what happened to him.

Q. There's not hospital records to support that history?

A. We can't conclude it wasn't severe enough.

Q. When were you retained by Mr. Rompilla's lawyers?

A. Sometime, I would say, a week or two [61] before March 5th.

Q. Now, can you tell me how you came to be retained in this case?

A. I can't, no, I just got a call.

Q. And did you know the person who called you from a prior occasion?

A. I didn't know Mr. Wiseman, no. I knew Mr. Nolas.

Q. Did you know him from the Clifford Smith case?

A. Yes.

Q. Did you actually give testimony in that case?

A. Yes.

Q. And when was that?

A. That was February.

MR. NOLAS: December of '95.

Q. And I think I understand from your earlier answers to my questions that that was the first time that you ever testified in this area in litigation in a capital case?

A. That's correct.

Q. You were in Philadelphia, I take it, from '83 through '89?

A. From '84 through '89 – well, I was in [62] the region, I wasn't in Philadelphia, I was in the region.

Q. Were you aware of any of your colleagues giving testimony in a capital case –

A. Never.

Q. – Commonwealth of Pennsylvania during those years?

A. No, I've never known anyone to give testimony in this type of case.

Q. You know now that type of testimony is being offered in these capital cases?

A. Yes.

Q. How did you become involved in the Clifford Smith case with Mr. Nolas?

A. There was an attorney from a private law firm whose father was a famous surgeon at the University of Pennsylvania. He called a psychiatrist. This lawyer called a psychiatrist, well-known psychiatrist, in the, area of depression at the University of Pennsylvania and asked him for the name of someone. The psychiatrist, Dr. Stinett, gave him the names of two neuropsychologists, one from the department of psychiatry and myself in the department of neurology, and the one from psychiatry wasn't in town, so he got me.

[63] Q. So you got the job?

A. Yes.

Q. Did you have a report from Dr. Paul Gross, have you ever seen that report?

A. Yes.

Q. It's been offered as an exhibit in this case. I think it's Defense 1.

A. Where is the date on this?

Q. I can tell you it's June 4th, 1988. You won't see it on the notes attached to it. You will have to take my word for it.

Have you ever seen that?

A. I don't believe I have.

Q. Did Mr. Rompilla in the interview, and I don't see it on your report that's why I am asking you, did he ever describe to you episodes of alcoholic blackouts?

A. I asked him, and I believe he said, he hadn't had any.

Q. Is there a distinction between an alcoholic blackout and what you described earlier as he used to drink until he passed out?

A. Yes, there is a distinction.

Q. The hospital records indicate when he was two years old he had a temperature of 105 and [64] diarrhea.

Do I understand, is it fair to say, you're not saying that that shows any brain damage at that time, you are not making the connection, are you?

A. I am saying it could potentially cause injury, but without more information on the duration and severity of the problem, I couldn't make a more probable statement about it.

Q. It possibly could have done it because we know sometimes fevers can do that, but you would need to know the duration of the diarrhea and the fever?

A. Exactly.

Q. On these prison records from 1975, did you take into consideration the Beta IQ test done at that time? Do you see the scale of 93?

A. Yes. I have to tell you I am not sure what the Beta scale of 93 means.

Q. You see the word average in the same column?

A. Yes.

Q. Is that an average person's average Beta score in –

A. I believe it's the low end of the [65] average score range.

Q. You said something interesting about all the neuropsychological tests you did. Correct me if I am wrong, that they have been around from the 1960's and '70's?

A. Particular ones I used have been around that long.

Q. Does that mean in the last thirty years, that the field of neuropsychology hasn't come up with any new tests?

A. Well, some of the tests they have come up with are tests I have made, and some of those are in here, but most of these tests derive from the '60's and '70's.

I am in an experimental environment where new tests are being developed all the time. You can't take – new tests are designed to explain certain specific hypotheses, that makes them less than useful. For a neuropsychological battery you have a frankly limited period of time, for us it's a very limited period of time to test the people.

You have to – I believe any neuropsychologist would want to use the two tests with two qualities, specificity and sensitivity.

[66] Sensitivity means what proportion of people who are impaired will be picked up. Specificity means how often can you detect a specific type of brain injury from the test.

So I have honed in on a battery of tests that I believe serve both of those purposes best, and they happen to include tests that are from the '60's, '70's, and also the '80's, just most of them go back that far.

Q. My question though is had you been retained back in 1988, for the issue of offering mitigating evidence at Mr. Rompilla's trial, would you have been able to do all these tests you did in 1996?

A. Let me see if there were any of them that weren't around then.

All of ones he was impaired in were around at that time. There's semantics sequential working memory test is one I developed or used in multiple sclerosis. It's based on an older paradigm. Auditory selective attention test is one that I developed. It's based on an older paradigm. It's just that the tests are improved and so on.

Number one, everything he was impaired in was around at that time, and all I can [67] tell you, the vast majority of the tests were also around at that time.

Q. I probably was not listening, I apologize. What does WNL mean, when you have that?

A. It means within normal limits.

Q. Did you testify that way before or did I –

A. No. That didn't come up before.

Q. Do you have experience, have you given these tests that you gave to Mr. Rompilla to many other persons?

A. Yes, I have.

Q. Have you given them to many people who are in the state penal system?

A. No.

Q. What type of people have you given these tests to before?

A. I have been giving them to people at the age of about 14 or 15 to the age of 94 might be the oldest. I have given to those people who are normal and have come in for neurological exams.

The people that come in as part of their neurologic work up are people who have various types of dementia, learning disability, attention deficit disorder, head injury, multiple sclerosis, [68] toxic exposure. I have probably the widest range of patient types of any neuropsyche lab in the city, because it's a neurology department.

I also take the referrals from psychiatrists. I do have people with psychiatric – primary psychiatric diagnoses who I give the tests to as well, psychologists. That probably answers your question.

Q. Your review of the prison records, I assume, has led you to conclude that Mr. Rompilla has had a long life of incarceration, correct?

A. Yes.

Q. And crimes when he's not incarcerated?

A. Yes.

Q. But just so I am clear on this, you haven't given your test to other similarly situated people?

A. Well, aside from Clifford Smith, no, not to people with long histories of crime.

Q. Are you in any position to say whether or not you were surprised by these results, these wouldn't be typical with a person with his prison record?

A. Let me just say that there is research on neuropsychological testing of people who are [69] violent, and basically that research says that there is not much neurocognitive deficit in that population, with the exception of impulse control. They don't do that poorly on neuropsychological tests.

Q. Except for impulse control parts?

A. Yes, which may be qualitative in nature. There are not many tests of impulse –

Q. Is it your opinion Mr. Rompilla is an impulsive person?

A. See, I guess it's – what's going on in my mind is the definition of terms, what do you mean by impulsive. There could be a range, all of us can be impulsive. It's not normal to be impulsive. There's all the way down to impulsivity of a severe kind due to damage to specific structures in the brain. Then there's everything in between.

I think there are certainly conditions when he becomes angry by something, when he becomes very impulsive. For example, during my testing, he didn't display an unusual degree of impulsivity.

My concern about him and impulsivity has to do more with the knowledge, the thoughts he has that he bases his actions on. I [70] think that's where he's most limited is the information he uses to look at something, to think about something, and then to make a decision or to act on something is probably very, very restricted or limited.

Q. You talked about a card game incident he related to you on your direct examination. I believe, if I am not mistaken, I think you said he does have the tendency to act violently without thinking.

Did you say that?

A. I used that as an example of him doing that, yes.

Q. Well, do your test results, are they consistent with that conclusion, he's the type of an individual who will act violently without thinking?

A. I didn't provoke him. I can't use my test results directly to test his response to provocation or stress.

Q. None of the tests you did analyzed that?

A. No.

Q. Ability –

A. The only aspect was his performance on the problem solving test when he was unable to hold his train of thought. That could be construed as a [71] type of impulsivity because your mind shifts to something else

before you process something. That – it's a matter of terms. That's a norm of impulsive or poorly controlled thinking. It's mainly what you are thinking of as impulsivity.

Q. So I am clear, you never did formulate the opinion he was the type of a person that would act violently without thinking?

A. I guess what I am saying, I didn't assess him for that. I could have an opinion on it. It would be not the same kind of opinion as my opinions on the test results.

Q. Now, are your tests 100 percent foolproof?

A. What does foolproof mean?

Q. You indicated on direct there was some evidence that you had that Mr. Rompilla was not faking?

A. Um-humm.

Q. What I want to ask you, are you incapable of being fooled by a person who is taking your test?

A. You are asking a question that is a double bind for me because you are asking me to make a subjective assessment which is inherently [72] nonobjective. So I can't – either way I answer, I am going to be wrong.

Q. I don't follow that at all. The question is pretty simple, Doctor. Can you be fooled?

A. If I say yes, I can be fooled, then of course that means I am not doing a very good job.

Q. I don't want you to answer with regard to what the results or how we will think about it. Just the honest answer.

A. My opinion is I am not fooled when I test patients, that's my honest opinion.

Q. The question is can you be fooled?

MR. WISEMAN: I object to the form of the question.

Q. You may answer: Can you be fooled?

A. Is it possible for someone to be fooled?

Q. Yes. I think that's how I phrased it the first time.

A. I think it's possible to be.

Q. Let me ask you this, in respect to your examination of Mr. Rompilla, do I take it that you have only done an examination on a person in his setting only one time before and that was the Clifford Smith case?

[73] A. I have done neuropsychological evaluations of other people that committed crimes. You said long prison records that committed capital offenses.

Q. Was it clear to you Mr. Rompilla understood why you were there giving him these tests?

A. I think he only understood partially. I don't know how much he understood.

Q. What part do you think he understood?

A. I think he was – I didn't inquire about this with him. I didn't discuss this with him. So I am going to make educated guesses. I think he understood that this neuropsychological testing could be helpful to save his life.

Q. How many times had you tested a person who had his life at stake?

A. Life at stake – I mean, I have tested prisoners on death row in San Quentin state prison giving them psychological tests as part of my Ph.D. dissertation.

Q. Did any of them have petitions outstanding?

A. I have no idea.

Q. That's how I want you to characterize my [74] question. Do you know of any other people other than I guess Clifford Smith and Mr. Rompilla who had petitions outstanding at the time of your examination to set aside their death penalty?

A. I only know of one other, one other, Clifford Smith.

Q. You will agree with me Mr. Rompilla, from the history you have seen, has been tested before?

A. Yes.

Q. These aren't the first psychological tests he's received?

A. Yes. I made sure I used different forms of the test so I wouldn't give the same tests again to him.

Q. With all that as background, are you saying that you don't believe you were fooled in this case but it's not impossible that you were?

MR. WISEMAN: Objection. That wasn't her answer. She said it's possible she could be fooled.

Q. The question stands.

A. My assessment is based on valid information. If I don't get valid information then my time has been wasted

and the patient's time has [75] been wasted. Therefore it's a very important part of my method to make sure I am getting valid information. This isn't a casual effort on my part. It's a constant effort on my part to make sure I am getting valid information.

I do this in various ways. I encourage the patient to take more time to solve the problem or to answer the question. I encourage them, give them positive feedback, which believe me, they always like. They don't get gratification by not doing well. They get gratification by being told they are doing well. That's a normal human reaction as opposed to a faking human reaction.

I look at the – whether there's anything abnormal that is unexpected, something that doesn't fit brain function coming out with the test. So there's consistency of the behavior to what's known about brain function. I watch the person's behavior just as a psychologist, which I am watching how they react and what they say and so and so forth.

Then I gave him a test directly of faking, that tends to pool for faking to get an objective measure of whether he was faking or not.

Based on all of that – based on [76] all of that my goal is to get the highest functioning that a person can perform, because I need to be making a differentiation between what's organic and what's something else. I don't want to know about something else. I want to know about what's organic. Then fit the rest of the picture in.

So I believe that, you know, the performances I got from him were the best he was capable of. That means he was not faking.

Q. The question was, is it fair to say that your conclusion is you don't believe that you were fooled but it's not impossible that you were?

A. Yes, I would just say I don't think I was fooled because it's not a matter of my belief. There's evidence and data I obtained.

Q. The subjective test, that's the one that was real simple but you tried to make it look hard, is that right, this is your objective test for faking?

A. Yes.

Q. I take it the fact there exists an objective test for faking is an indication that sometimes we expect people are going to try to fool us when we are doing these tests, right?

[77] A. I don't think you can say we expect people to. I think it's true these tests were designed for litigation purposes. So it doesn't mean people normally do this.

If you analyze the base rate, the likelihood of it occurring is very, very rare, 1 in 20,000. I may have seen a lot of patients but I haven't seen 20 patients. The likelihood of my having seen a faker is very low.

People make their careers – the way – people have done a lot of research in trying to find out what is a neuropsychological pattern of faking. No one has been able to find one. The only thing you can do is use, you know, these symptom validity tests and look at the MMPI which I couldn't give him because he can't read well enough.

Q. You couldn't give Mr. Rompilla an MMPI?

A. Not unless I sat and read him every question, it would take a couple hours to do that, five hours.

Q. Did you have some time limit that you had to have with him?

A. A plane, I had to catch a plane.

Q. Did you say five hours?

A. Five hours.

[78] Q. I take it all these other tests you gave were a lot shorter than the MMPI?

A. Yes.

Q. The objective tests for faking, was that one –

A. No, it's a sheet of information that they look at for about as long as they need, ten seconds or more. I gave him more time. I take it away. There are 15 items on this sheet. I ask him to write all the items down, 15, 16 items. Then I ask him to remember all the 15, 16 items after seeing them once.

If I normally showed you a sheet of paper with 16 words on it, you wouldn't be able to get all the 16 words. We expect them to get all 16 items.

Why is that, because the items are things like A, B, C, D, in small letters. Then Roman numerals, one two, three four. Maybe capital letter A, B, C, D, then maybe Arabic numbers one, two, three, four. It's so well clustered it's easy to remember that pattern. Someone who is trying to fake sees this as an opportunity to say, well, you know I can't get it all.

Q. How long did that test take?

[79] A. That test took whatever, 20 seconds.

Q. Do you remember how many he was able to remember of the 16?

A. All of them.

Q. He was able to remember all of them.

MR. McINTYRE: I have no further questions.

* * *

REDIRECT EXAMINATION

BY MR. WISEMAN:

Q. Is there any evidence in the school records from when Mr. Rompilla was in elementary school that he malingered in '59 through '61 when he scored in the retarded range on the WISC test?

A. I have never seen anyone study malingering in children, I have to tell you. Children generally –

Q. You would assume those are valid scores?

A. Yes. The other point, they were given repeated times and he scored in the same range.

Q. In fact contrary to malingering children would want to try to do if they could?

A. Yes, they are very eager to please.

Q. The IQ scores from that period in his life are consistent with the organic deficits you [80] identified in your present day testing?

A. Yes.

Q. Does Mr. Rompilla have the intellect wherewithal in your opinion to fool a neuropsychological test, would he know how to do that?

A. At the think if he wanted to do it, which he might want to do, that he would do it by – in some very awkward clumsy way. He would probably first say, sorry, I can't remember anything. He would probably say – or he would never be able to select out information. Some of which to recall and some of which to not.

Why, because it takes memory to do that. You have to remember what you are supposed to, and then decide what you are going to do and not do. He doesn't have the capacity to do that. That's complex reasoning. He would be completely unable to do that.

Q. Did he appear to you to be trying hard when he took the test?

A. Yes, he definitely appeared to be trying hard and was pleased when he did well.

Q. Did he in fact do well on quite a number of the tests you administered?

[81] A. Yes, he did. I wouldn't say quite a number. But he did well on a number of them.

Q. Mr. McIntyre asked you about an MMPI or I think you discussed with Mr. McIntyre an MMPI. Let me show you an MMPI that's a part of the 1975 DOC testing.

Are you familiar with how to read the scales?

A. Yes.

Q. Are the validity scales on that MMPI valid?

A. The validity scales are not here. I'm sorry. I am looking in the wrong part. Pardon me. The validity scales appear to indicate a valid test, yes.

Q. So when he scored – when he took the MMPI in '75 he, according to the MMPI results themselves, he was not malingering?

A. That's correct. The mailing – whether for primary second gain or call for help reasons, which is not a matter of gain but a call for help, basically are defined by an F score of 80 or above. His score of 64 is in a very normal range. So it's not there.

Q. Now, the testing that you administered, [82] do those tests have groups that sort of set the norm by which you then compare the patient's performance?

A. Yes.

Q. And do the groups that make up the norm consist of normal people, among others?

A. They are supposed to be screened to consist of healthy normal people.

Q. And intelligent people?

A. No, just healthy normal people.

Q. Are there psychiatric patients in that group?

A. No, there should not be any.

Q. Just normals is what I guess you guys call them?

A. Yes.

Q. Have you had occasion to – the implication of Mr. McIntyre's questions seem to be that Mr. Rompilla had a motive to malinger.

Have you tested other people in your career who have had a motive to do badly, not actually malingered but who have had a motivation?

A. Yes.

Q. Could you give us an example of such people?

A. People who are a plaintiff in a case [83] regarding negligence or product liability or car accident, personal injury.

Q. People would want to show they suffered severe damage?

A. Yes.

Q. You have experience then in determining whether the tests are valid, whether people have motives to conceivably linger?

A. Yes. I have to say a good part of my knowledge in the area comes from my six years at Bryn Mawr Rehabilitation Hospital where I also managed the mild head injury program which is a group constantly being pointed to as being filled with malingers.

The advantage is that I got to, one, treat people over years in time because they are mild head injury people. I got to talk to them and family members, five, ten, fifteen, twenty years after their injury. I got to have a very long-term view of people with these invisible brain injuries which gave me a lot of insight into how humans really do react to brain injury.

One basic problem is that it's actually not to their advantage – humans have a much stronger need to think of themselves as being [84] normal and good and okay. And malingering really goes against that. To present yourself as being incapable is something that very few humans will want to do.

Q. There was a number of questions both on direct and cross-examination regarding impulsivity. I think you were explaining in cross there's a spectrum of impulsivity in people. Normal people have some impulsivity, and then there's people at the other end of the spectrum.

Could you explain how Mr. Rompilla's degree of impulsivity is affected by his reasoning problems that you identified in your testing?

A. Yes, I mean – I don't know how well I said it before. What I was trying to say, you could have impulsivity because you are not – because higher levels of the brain are not controlling thoughts, or you could have impulsivity because there is a hormonal disturbance or lesion in the motivation part of the brain, which is an unusual place to have a lesion; except for a very severe head injury that could lead you to have – I mean at that point behavior doesn't get to the point of higher controlled areas. That's why I need to [85] define what impulsivity is.

I see him having a problem of the first type. Mental thought – thought problems that reduces the ability to control, to guide his behavior. It's a monitoring and guiding problem.

If he's going to act impulsively – I haven't done blood level tests to examine whether he has, you know, neural transmitter hormonal problems that would indicate a

psychiatric type of impulse control impairment, but he does have cognitive impairments that cause him to act without thinking.

From that – that's the definition of impulsivity that I see in the testing.

Q. Is there any way for a mental health professional to assess brain damage other than through neurological or neuropsychological testing?

A. Brain imaging scales.

Q. That would be a neurological test?

A. We break it down. That's a neuroradiological test, that's a medical test. You mean outside of medical and psychological tests?

Q. Exactly.

A. No.

Q. You indicated in response to questions [86] about the Beta IQ, you weren't familiar with it. Were you familiar with the WAIS and the WISC?

A. Yes.

Q. Is one used more frequently than the other? In other words is the WAIS and WISC used more frequently than the Beta?

A. Yes, the Beta has been used almost exclusively in army soldiers. WAIS and WISC has been used in basically all other testing, even in some employment settings, but school settings, medical settings, research settlings, almost all other settings.

Q. Is the Beta as sensitive an instrument as the WAIS?

A. No. That's why the WAIS was developed. Previous to the WAIS were tests like the Beta. Although Beta wasn't probably one of the strongest but probably easiest to administer. Tests based on the idea you can pick out a certain type of problem and that will be sensitive enough to IQ – to give you a valid measure of IQ, but the WAIS was developed because they finally concluded that there was no one kind of problem that was sensitive enough to intelligence, that people have many types of [87] intelligence. It was created to scan many types of intelligence and it takes about two hours to give, which is, I know, longer than the Beta takes.

Q. Are you aware of any differentials in the scoring scales between a Beta and a WAIS or WISC?

A. I can say the WISC and WAIS are known to have – there are many – several other IQ tests, have the best most accurate scaling. However, even those tests I might say tend to under – tend to underestimate – I'm sorry, tend to overestimate the low measures and underestimate the high measures.

People at the low end of the IQ tend to all be grouped into the same levels. The lower your IQ the more difficult for the test to measure, same at the high end. The higher IQ the – the scaling narrows at the high end and at the low end. It could potentially underestimate someone with a low – overestimate someone with a low IQ.

Q. Couple other questions, Mr. McIntyre asked you a difference between blacking out and passing out. He

doesn't ask you the follow-up, could you tell us what the difference is?

A. Blackouts can occur even when the person isn't intoxicated. They aren't necessarily becoming [88] unconscious as passing out is. Some degree of unconscious, black outs, can occur while a person is aroused and able to move, but they have complete memory lapse and awareness lapse. They completely lose that period of time, even though they are behaving and moving around.

Q. Is it fair to say passing out is intoxication of high levels, drink you to pass out?

A. Yes.

Q. Blacking out is more of a neurologic manifestation?

A. Of the drinking.

Q. Last question is you refer to some of the testing from 1988 regarding, I think, a WAIS score. Was that testing that was from the Department of Corrections, do you recall?

A. Yes, I think so.

Q. Have you seen any testing from a Dr. Cooke in this case?

A. I don't recall right now. Can you refresh my memory?

Q. I don't think I can. The question simply is have you seen it?

A. I don't recall seeing it.

Q. Any testing from any psychologists or [89] psychiatrist in '88 other than the DOC WAIS you just mentioned.

A. I, saw a statement by a psychologist, I didn't – I don't know what the full range of tests are he gave. He commented in some statement he gave on some of his findings.

Q. Would that be Dr. Gross?

A. Dr. Crown.

Q. Dr. Crown is – in the packet of materials you received from counsel, did you receive a declaration from Dr. Crown?

A. Yes.

Q. He's the gentleman from Florida?

A. Yes.

Q. He did testing in 1995?

A. I'm sorry. I am confusing it with '88. Sorry.

I need to rely on the records in front of me.

Q. That's okay.

A. Yes, I confused those. I did see partial information from 1988.

Q. Partial information you saw was that DOC testing?

A. Yes, that's correct.

[90] Q. Was there any other information from '88 that you ever saw?

A. No.

MR. WISEMAN: No further questions.

* * *

RECROSS EXAMINATION

BY MR. McINTYRE:

Q. Just a couple questions, you mentioned medical tests for organic brain –

A. Yes.

Q. There are medical tests?

A. There are other tests, yes.

Q. There are medical tests?

A. Yes.

Q. You call it a medical test?

A. Correct.

Q. As opposed to neuropsychological tests?

A. Yes.

Q. One of them is an EEG?

A. One of them is an EEG.

Q. One of them is a CAT scan?

A. Yes, or an MRI scan or SPECT scan or PET scan.

Q. Did you do or have any of those tests [91] done to corroborate your tests?

A. I don't have privileges to have them done. There's no funding. If I could have I would have those tests done.

Q. Did you suggest to Mr. Rompilla's counsel to have those tests done?

A. I didn't only because I didn't think it was possible.

Q. It's [sic] simply requires a yes or no. You don't have to get defensive.

MR. WISEMAN: I object to the characterization.

MR. McINTYRE: I think it was an accurate one.

MR. WISEMAN: You don't have to be offensive. She answered the question.

MR. McINTYRE: Unfortunately she didn't, Michael.

Q. Did you request Mr. Rompilla's counsel –

MR. WISEMAN: She answered the question. She said no, and she told you why.

A. I wanted to have the tests done. I didn't request them because they weren't possible.

Q. So you did not request –

[92] A. That's correct.

Q. – to have those done?

A. That's correct.

Q. But surely it would be possible for them to get those done, wouldn't it?

A. No, he's in prison.

Q. You can't get him out to have testing done?

A. I am not aware of that possibility.

Q. Okay.

A. I am not aware of being able to fly him to the University of Pennsylvania in shackles to be tested.

Q. He could be driven in a vehicle I suppose. Strike that. We don't have to get into this.

I think I have one more when I think about it. All of these medical tests don't require us – strike that.

They are objective tests, the patient doesn't have to say a thing for them, right?

A. That's correct. Let me say they are not what's considered the gold standard of brain impairment. Neuropsychological testing is considered the gold standard.

[93] Q. Is neuropsychological testing the most sensitive for brain damage testing?

A. It is. I have tested a patient who had serial magnetic resonance imaging scanning for years. In my testing I found visuospatial processing deficits.

Two or three years later the MRI scan finally found the tumor. There's a good case of neuropsychological deficit being found prior to MRI scan.

Q. Is that what you mean by the gold standard, most reliable testing?

A. Most sensitive testing, most likely to find the impairment.

MR. WISEMAN: Nothing further.

MR. NOLAS: So the record is clear on every previous occasion when an MRI, EEG, SPECT scan or other such testing has been requested, the Pennsylvania Department of Corrections has refused, refused to allow inmates to be taken out of the Pittsburgh facility or any other facility for such testing, refused to allow practitioners to bring their equipment in where possible to undertake such testing and has essentially limited us to neuropsychological testing. Given the fact that [94] that testing is more sensitive we have relied on that testing in Mr. Rompilla case and other cases.

MR. McINTYRE: Thank you. Would you state for the record whether or not you attempted to ask a Court or seek a Court Order for this type of testing?

MR. NOLAS: Yes, we have.

MR. McINTYRE: Have you done so in this case?

MR. NOLAS: We most recently requested it with Judge Toole in Wilkes-Barre in the Strong case.

The Department of Corrections opposed the request and it was refused. We did not make the request in Mr. Rompilla's case given that prior history with the Department of Corrections and given the testing by Dr. Armstrong and Dr. Crown.

MR. McINTYRE: Thank you.

MR. NOLAS: I would also – there's also the element of the fact the Post-Conviction Defender Organization has been defunded. There's an economic issue as to how many tests one can order given we ordered what our experts tell us are the most sensitive neurological testing that exists.

[95] (Deposition concluded.)

[96] 4-12, 1996

I hereby certify that the evidence and proceedings are contained fully and accurately in the notes taken by me of the testimony of the within witness who was duly sworn by me, and that this is a correct transcript of the same.

SAS
Sally A. Slifer, RMR
Registered Merit Reporter
Notary Public

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COURT OF COMMON PLEAS OF
LEHIGH COUNTY, PENNSYLVANIA
CIVIL DIVISION

COMMONWEALTH OF PENNSYLVANIA,	:	NO. 682/1988
Respondent	:	
vs.	:	
RONALD ROMPILLA,	:	
Petitioner	:	

DEPOSITION OF PAUL K. GROSS, M.D.

Taken in the offices of Paul K. Gross, M.D., Suite 312, 401 North 17th Street, Allentown, Pennsylvania, on Monday, April 1, 1996, commencing at 6:15 p.m., before Mona Denise Ventresca, Registered Professional Reporter.

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[3] MR. WISEMAN: This is an examination of Dr. Paul Gross taken at his office. The parties have agreed that all objections will be made during the time of the examination, no objections will be reserved.

MR. McINTYRE: That's agreeable to me.

* * *

PAUL K. GROSS, M.D., having been duly sworn, was examined and testified as follows:

EXAMINATION

BY MR. WISEMAN:

Q. Doctor, what is your employment?

A. Excuse me?

Q. What is your employment?

A. I'm a psychiatrist.

Q. For how long have you been a psychiatrist?

A. I'm a psychiatrist for 21 years.

Q. Directing your attention back to 1988, were you involved at all in criminal proceedings in regard to Ronald Rompilla?

A. I was asked to evaluate him by his attorney, related to the charges that were leveled against him.

[4] Q. Do you have any independent recollection of your involvement with the case at this point?

A. Not much, its very sketchy.

Q. Prior to today, have you spoken with anyone within the last month regarding the proceedings presently going on in Lehigh County Court?

A. No, I did not.

Q. Back in – by the way, I see you have in front of you a copy of your report from 1988. Have you had a chance to review it?

A. I have had a chance, yes, sir.

Q. What's your recollection or your understanding of the purpose of your interview or evaluation, I should say, of Mr. Rompilla back in 1988?

A. Well, as it states in the first paragraph, I was asked to evaluate what his mental state was at the time of the alleged crime, and that's as much as I can tell you at this time.

Q. By the way, at the time you had done that evaluation, had you done other evaluations in capital cases?

A. Yes, I had.

Q. Do you roughly recall how many?

[5] A. I don't recall. I would say perhaps a half a dozen or so, in that neighborhood.

Q. Now, in your report – by the way, your report has already been marked as an exhibit in the case, so I'll refer to it as a report that's been before the court.

In your report you indicate the purpose of the evaluation is to determine Mr. Rompilla's mental status, you just said, during the time of the alleged charges. What's your understanding of what that entailed when you use the term mental state, what were you looking at exactly?

A. Well, I was looking to see if he knew what he was doing, whether he was suffering from any kind of psychiatric disorder, whether he may have been intoxicated, exactly what his emotions and cognitive processes were. As much as you can tell later from a psychiatric point of view.

Q. Now, the things you just listed, are they things that you would normally do in such an evaluation or are they things that you have a specific recollection of having done in this case?

A. No. I don't recall specifically doing anything in this case, other than to refer to my record here and my notes and so forth.

[6] Q. So would it be fair to say then the things that you just indicated that comprised your evaluation are things that you routinely do –

A. That's correct.

Q. – in a criminal case?

A. Well, really in any case it's part of a psyche id evaluation, the mental status at the time of the crime you're looking for abnormal trends.

Q. Have you ever testified in the penalty phase of a capital case?

A. I don't think so.

Q. Have you ever prepared specifically a penalty phase presentation for the defense in a capital case?

A. I don't believe so.

Q. Have you ever prepared a penalty phase for the prosecution in a capital case?

A. I don't think so.

Q. Now, if I could direct your attention to the last page of your report, in particular, the last two paragraphs. Why don't you just take a minute to refresh yourself.

A. Okay.

Q. In the very last sentence of the report it says, my recommendation is that this area should [7] be further evaluated before any definite conclusions are drawn. When you refer to this area, what were you referring to?

A. I was referring to his reaction to alcohol.

Q. Now, in the report itself, it appears that Mr. Rompilla denies drinking alcohol outside of, for lack of a better term, socially. Would you agree with that characterization of what he apparently told you at that time?

A. The report apparently suggested that he was not an alcoholic and he was not drinking that heavily that it caused a problem, in his opinion.

Q. Given his statements to that effect, why did you recommend that that particular area be explored further?

A. Well, there is a condition in psychiatry where somebody behaves pathologically to alcohol. And certainly someone can be an alcoholic also and deny it, and do things under the influence of alcohol which would have influenced their behavior.

Q. I guess what I'm getting at is did you have any other information at the time that would have led you to want to explore that area more completely?

[8] A. Only as my report suggested, that he was drinking that day and he did say he was drinking. And that there certainly is that possibility that he was drinking more than he remembered or cared to remember.

Q. Now, long term effects of alcohol can in some cases cause organic brain damage?

A. It can.

Q. Is there any relationship between that possibility of brain damage and blackouts?

A. It can be. People with brain damage I think are more prone to have blackouts than those without them.

Q. So effectively then, when you represented that the alcoholic blackout possibility be explored further, that would include the exploration by definition of the possibility of organicity?

A. Again, there are lots of things to evaluate under the heading of possible alcoholism. That's one of them. You know, there might be others as well, but that's certainly one of them.

Q. Do you recall, after you wrote this report and submitted it to counsel, whether you had any further involvement in this case?

[9] A. I don't recall I had any further involvement.

Q. So counsel didn't come back to you and ask you to do additional things?

A. Again, I think my letter was submitted and I think that was the last I heard of it.

Q. Just so the record is clear, you've searched your files and you have no other material in this case?

A. I have no other material.

Q. By the way, the exhibit in court includes your handwritten notes that were part of your report?

A. Right.

Q. Now, in that next to the last paragraph of your report, you refer to a strong element of antisocial behavior of Mr. Rompilla. Is that right?

A. That's correct.

Q. I gather that he told you things or you saw things in his record that had an antisocial flavor?

A. Absolutely.

Q. You don't make a diagnosis here of antisocial personality disorder here, do you?

A. I didn't in this report.

[10] Q. I just want to get your views on a couple of thoughts regarding antisocial behavior. And for the record, I'll be referring to – well, let me ask you a credentia question. The Comprehensive Textbook of Psychiatry by Kaplan and Sadock, are you familiar with that work?

A. Yes, I am.

Q. Is that a standard reference in the field of psychiatry?

A. Yes, it is.

Q. And it's one that you use in your work?

A. Yes, it is.

Q. Now, I'm going to be referring in these questions to a passage in the section of Kaplan and Sadock, section 28, adult antisocial behavior and criminality, specifically on page 1402. I just want to read you a portion and see if you agree with this or not. Quote, a consistent finding in the histories of extremely violent recidivists is a history of

having been severely physically abused. Such is the case, whether one studies children, adolescents or adults, or whether one considers violent psychiatric patients or violent prison inmates, end quote. Do you agree with that same in Kaplan?

[11] MR. McINTYRE: Michael, let me put an objection on the record.

MR. WISEMAN: Just so the record is clear, what's the basis?

MR. McINTYRE: You can use learned treatises to cross-examine a witness, but you certainly cannot use learned treatises to get the part that you're reading in as substantive evidence, which is the only purpose I guess you're using it for.

MR. WISEMAN: No, there is another purpose. Just so the Judge is clear if he reviews this, the purpose is to see why or why not this particular expert took particular actions and predicates for the actions he took.

MR. NOWLAS [sic]: In addition, so that the record is clear, Dr. Gross was involved –

MR. McINTYRE: Hold it, guys, you're not going to tag team me here. That's not right, one lawyer is doing this deposition.

MR. NOWLAS [sic]: Fair enough.

Q. Do you agree with that statement in Kaplan?

A. Yes, I would agree with that.

Q. Just one more brief statement from that [12] section. Quote, whether violence toward children occurs

when parents are under the influence of alcohol or delusional and believe they are exorcising the devil, are in a manic frenzy, or are simply disciplining in the only way they know, the experience of such aggression seems to have lasting effects on the victims. There are several ways in which being the object of such violence contributes to the development of antisocial behavior.

First, it provides a model for behavior. Second, it frequently results in injury to the child's CNS, thereby impairing the child's ability to control impulses, think logically, function adequately at school, and behave in socially appropriate ways. Finally, it engenders rage in the victimized child, which frequently seems to be displaced onto teachers, peers, and even strangers, end quote. Do you agree with that statement?

A. Yes.

Q. Would it be fair then, Doctor, to say that when you see antisocial elements in someone that you're evaluating, one of the areas that you need to rule out as a cause for that behavior could be that the person had an abusive childhood?

[13] A. Yes.

Q. All right. On page 1403, I just want to read to you two sentences. One sentence, actually, and see if you agree with this. Quote, most have histories of school problems, learning disability, especially reading problems – I'm sorry, that didn't make sense, I read that out of context. Let me try that again. Many, referring to abused children in the context of the passage, have identifiable cognitive impairments, manifested by wide discrepancies on subtests of intelligence scales, poor short-term memory, and impaired

reasoning on mental status examination. Most have histories of school problems, learning disability, especially reading problems, and altercations with peers and teachers. Would you agree with that?

A. Yes.

MR. McINTYRE: Attorney Wiseman, what's the date of that article?

MR. WISEMAN: This is the 5th edition, which I believe is 1994.

MR. McINTYRE: And you're aware that examination in this case took place in 1988?

MR. WISEMAN: Actually I think it's 1989.

[14] MR. McINTYRE: Note my objection on that basis, as well, that we can't be using materials we've garnered or gathered since 1988.

Q. Has anything in regard to the – does the field of psychiatry have a different view now in 1995 than they did in 1988 on the issue that I just presented to you?

A. I think that sounds consistent with what was known in 1988 on that particular issue.

Q. How about the prior passage, would there have been any difference?

A. I don't think there would be any major differences in thinking on that issue either.

Q. All right. Doctor, so, again, if you're evaluating someone who has antisocial elements in their background, would it be an appropriate response for an evaluator to consider whether the patient has a history of cognitive

impairments as perhaps a cause of their antisocial behavior?

A. Well, yes. My understanding is that antisocial – there may be cognitive problems, but that it plays a small part in that, that actually we're talking about a larger issue. And that these are people who have absolutely no conscience and no guilt and no allegiance to a group. And, you know, [15] do things really for their own self-gratification and very angry people. But that, you know, it's my understanding that the cognitive slight brain damage, if you will, is not a major etiologic factor. That has to do with the way they were raised by their parents more than being damaged cognitively or physically in their brain. That's my understanding.

Q. Well, I guess my question is directed more towards before you reach a diagnosis of antisocial personality disorder. In a particular case when you're evaluating elements of antisocial personality disorder, do you look to see if there are any cognitive impairments as part of that evaluation?

A. I think you do that with any psychiatric evaluation to see if there's any organic or cognitive problems. But I don't think you do it more so for antisocial than you do for anything else, actually.

Q. Now, would you agree that – I think you did agree already – that one of the causes of antisocial type behavior is an abusive upbringing. Is that right?

A. I think that's commonly thought of and [16] agreed to, that's right.

Q. Upon page 1404 of Kaplan there's a short paragraph that says, family histories, especially regarding

aggressive behaviors, are essential. Delinquents and adult criminals are usually reluctant to admit that their parents have hurt them physically. Questions are answered more easily if phrased in such a way as to blame the patient, in part, for parental loss of control; e.g., quote, did you ever make your mom so mad she lost her cool and went further than she meant to, end quote, closed quote. Do you agree with that statement?

A. I would agree with that.

Q. Do you recall in your evaluation of Mr. Rompilla whether – well, withdrawn.

Did you discuss with Mr. Rompilla issues related to an abusive upbringing or family violence?

A. Yes, I did. Actually he denied any abuse as a child, by either parent. He said he had a good relationship with his father and he denied any abuse by his mother. Actually what he said was that he had a, quote, fairly normal childhood except for the fact that he didn't like school, which he left in the ninth grade. So what he described to me [17] was really unremarkable in terms of his childhood upbringing.

Q. Did you speak to other members of his family?

A. No, I did not.

Q. Did you – well, let me ask you this. Was your report on those issues based solely on what Mr. Rompilla told you?

A. Yes.

Q. Now, one more passage, I think we'll be done with this portion of the exam. Again, from 1404, no matter how thorough the psychiatric examination itself may be, there are aspects of functioning that should be conducted by experts in other disciplines. For example, the results of routine psychological tests are invaluable. Moreover, more specialized neuropsychological tests, such as the Halstead-Reitan and Luria-Nebraska Tests, often reveal organic deficits not elicited in either the psychiatric or the routine psychological examination, end quote. Do you agree with that?

A. I think that you can pick up, certainly, things in testing which you're not going to pick up in a clinical evaluation, that is true.

Q. Would it be fair to say that if there's no reference in your report to any psychological tests or neuropsychological tests, that you had none at the time of your evaluation?

A. That's correct.

Q. In other words, if you'd had them, you would have incorporated them?

A. That's right.

Q. Now, as this man is just referring to in the psychiatric examination, he needs to go to these other disciplines. You said other testing can pick up things. Why is that important when you're evaluating someone who is showing antisocial type –

A. It's not, I don't believe it's important when you have an antisocial behavior unless there's evidence of organic deficit. What I said was I don't think it's important

to do that. What's important is really the childhood issues and emotional issues and childhood, that may be the answer.

But I don't believe that organic brain dysfunction causes antisocial behavior. I think it may be a slight factor and I believe you're taking this out of context. So that – I had no suspicion at all in this evaluation that this man had any organic deficits at all. There was nothing [19] at all in this interview that suggested he had cognitive impairment at all. So as far as I was concerned, there was no reason to go into anything other than what was very straightforward about this case.

Q. All right. Now, you just said that – I think at the beginning of that answer you said there's some reason, although not a main reason, to go into organicity or did I mishear you?

A. No. My opinion about antisocial people is that there's no reason to delve into organic deficits to explain antisocial behavior. That in general, they are due to childhood experience in a very unhealthy family, and that causes the antisocial behavior.

Q. Let me back up then. You agreed with the statement in Kaplan that it's important to have organicity looked into. I guess my question is why?

A. I'm not going to disagree with an expert if that is his opinion. In my experience, I don't think it's fruitful to do that in cases of antisocial behavior because I think that's not where the defect is. It's not an organic brain disorder, it is a personality disorder that is caused by real, faulty dysfunctional family relationships.

[20] Q. Now, would you agree that bruised children often manifest central nervous system deficits?

A. I think they can and especially if there's head trauma. Mr. Rompilla gave no evidence of any head injury, I asked him that question, abuse of any kind that would suggest that there was any organic brain disorder.

Q. All right. I guess what I'm getting back to then, Doctor, is that given that there is some correlation between central nervous system deficits and abuse, and since abuse can explain certain antisocial behaviors, isn't there a connection between looking towards central nervous system deficits when you're dealing with someone who has an antisocial presentation?

A. I think if you suspect that the person has been physically abused, especially abuse of the head, then you should look into it. If there's no evidence of that, then I think you're on a wild goose chase.

Q. Just so the record is clear, because we're talking about antisocial personalities, again, your report does not diagnose him as antisocial. Is that right?

[21] A. Antisocial is a psychiatric term, it is a personality disorder. So when we talk about antisocial, psychiatrists generally mean it's a personality disorder.

Q. A personality disorder, an antisocial personality disorder is arrived at after a checklist of things are determined and checked off. And that diagnosis is not in your report, the formal diagnosis for DSM is not in your report?

A. I was not asked to diagnose him, just to look at his mental state. So I felt that I did what I was asked to do at that time and not go any further.

Q. Just a couple questions about organic brain damage. Doctor, does organicity relate to impulse control?

A. It can, it can explain it.

Q. Can it impair one's impulse controls?

A. Yes.

Q. Does it relate to problems with cognition?

A. Yes.

Q. And problems with judgment?

A. Yes.

Q. Problems with reasoning?

[22] A. Yes.

Q. And emotional lability?

A. Yes.

Q. Are these all things that I just mentioned that are relevant to mental functioning at the time of the offense? Hypothetically, not necessarily in this case.

A. A hypothetical question, it can be related to someone who commits a crime.

Q. In other words, all the factors I just ticked off that you agreed were part of an organic presentation relate to one's – potentially relate to one's mental function at the time of the commission of the offense?

A. It can, yes, it can.

Q. Now, is there a connection between child abuse and low IQ scores?

A. I believe there is a correlation between, you know, the more the abuse, the lower the IQ. I think that's just an intuitive kind of reasoning. I think it also stands up in testing.

Q. Now, let me ask you this, if you see a child with a low IQ score, is a possible explanation for that, that there's an organic problem?

A. That, absolutely.

[23] Q. And another possible explanation is that there's some environmental stresses, such as abuse or dysfunctional family?

A. Yes.

Q. Now, when you did your evaluation of Mr. Rompilla did you have at your disposal any IQ testing that he had had as a child or as an adult?

A. No, I did not

Q. Would you agree that abused children exhibit academic and behavioral problems in school?

A. Yes, I would.

Q. So if you saw poor functioning in school, that would be a potential red flag for an abusive background?

A. That's correct.

Q. And it would also be a red flag for possible cognitive impairments?

A. That's correct.

Q. Have you seen in your experience where abused children, often because of these difficulties in school, are placed in special education classes?

A. Yes, I have.

Q. Now, Doctor, I want to show you an exhibit that's been marked in this case. Actually, before we do that, let me just ask you a couple of [24] predicate questions. Did counsel, to your recollection, provide you with school records in Mr. Rompilla's case?

A. I don't recall having those records, no.

Q. Records from prior offenses?

A. No, I don't remember seeing those.

Q. Records from prior incarceration, including any psychological testing?

A. No, I didn't see those.

Q. Any hospital records?

A. No.

Q. Did they give you any records at all?

A. I don't recall nor do I note that I saw any other records.

Q. Would it be fair to say that any records you reviewed as part of your evaluation would be in your report?

A. That's correct. If I did review it, it would be noted.

MR. WISEMAN: All right. I'd like to show you an exhibit that's been marked.

Mr. McIntyre, I don't have my exhibit list in front of me, but it's the school records which I think were marked twice.

MR. McINTYRE: I've got them at [25] D-5 and D-8.

MR. WISEMAN: That sounds about right.

Q. In any event, just to give you some contact, Doctor, these are records that were retrieved from Mr. Rompilla's school. I'm going to ask you to – I'll just point to it since we're across the table. You'll see an entry at 4/57, Wechsler and you'll see a verbal score of 75?

A. Uh-huh.

Q. And then below it, 10/59, Wechsler, with a full IQ score of 64. Now, if you had had that material presented to you at the time of your evaluation by his attorneys, is that information that would have been useful to you in your evaluation?

A. Yeah. I think it is useful to note that when you're doing an evaluation, yes.

Q. And specifically, I think you said that there was no evidence of a cognitive impairment that you could see. But certainly those IQ tests are some evidence of a cognitive impairment?

A. That's correct.

Q. And those IQ tests are also evidence of potential dysfunctional family or abusive family?

[26] A. You don't know what it means. This person could just, you know, be kind of a borderline IQ without any abuse. But certainly there are a lot of possibilities.

Q. Let me just flip the page for you. There's another test here from 1961 with a full scale IQ of 69, again, on the Wechsler. Same question, that's information that you would have found useful in your evaluation?

A. Yes, it would have been useful.

Q. Now, if you would have seen those types of cognitive impairments back then, would you have thought it appropriate to have neuropsychological testing done? Keeping in mind that you don't do the testing.

A. I'm really not sure. I was not asked – because what I was asked to do was evaluate what his mental state was at the time of the charges. And I'm not sure if neuropsychiatric testing would help me answer that question any better in relation to whether, in fact, he knew what was going on and whether he was suffering from any psychiatric disorder at that time. I'm not sure how I would have dealt with that information.

I certainly would have wanted to [27] know more about it, perhaps with some medical records as a child to find out if there was anything more to it than that, you know, if that was ever looked at.

You know, this was a man who denied ever committing the crime to begin with, and really denied any problems at all on that day. I don't know if I would have done neuropsychiatric testing, given what he told me and what I knew about it. I might not have.

Q. Now, are you familiar with the phrase – well, I should say the word mitigating in the context of a capital case?

A. What phrase is that?

Q. Mitigating.

A. Yes.

Q. Are you aware of mental health mitigating factors in a capital case?

A. Some of them I am. Intoxication I believe is one of them.

Q. Are you aware of mental health mitigating factors in a capital case?

A. I think there are some psychiatric disorders that may mitigate, psychiatric symptoms that may mitigate.

[28] Q. Are you aware in your role as an expert in a forensic setting, that an abusive childhood can be a mitigating circumstance in a capital case?

A. No, I'm not aware of that.

Q. Do you have – are you aware of whether an organic deficit can be a mitigating factor in a capital case?

A. I'm aware of that.

Q. And how would that be a mitigating factor in your review?

A. Somebody with sufficient organic impairment would not be able to, for instance, have correct judgment about a situation. They'd be more impulsive than he should be, his emotions may be too intense and fluid.

Q. Lack of impulse control?

A. Lack of impulse control.

Q. Inability to foresee future consequences?

A. So that organicity certainly would be a factor.

Q. Now, in order to determine the existence of organicity, would it not be appropriate to endeavor to get to the neurological bottom of these IQ tests, if there is such a neurological bottom?

[29] A. I think if you're evaluating his cognitive state, I certainly think you'd want to get as much information as you could if that was what you wanted to do, sure.

Q. In the cases you've worked on, are you familiar – with the capital cases you've worked on, are you familiar with the circumstances of history mitigation?

A. Could you explain that?

Q. Do you see the role of the expert as gathering and compiling a history of the defendant as in an exploration for mitigating factors?

A. I think that's one of the roles of an expert psychiatrist, yes.

Q. Is there a relationship between neuropsychological testing and the assessment of brain damage?

A. Oh, absolutely.

Q. And so if you were setting out to determine whether there is, in fact, organicity, you would rely in part on neuropsychological testing?

A. Yes. If you wanted to find out about organicity, you would have to have neuropsychiatric testing among other testing, yes.

Q. Just to refine my question a little bit [30] more from a few moments ago regarding organicity as a mitigating factor. Would you agree that the presence of organicity has the potential to impair one's capacity to conform their conduct to the requirements of law?

A. I think sufficient organic deficits can certainly do that.

Q. Is organic brain damage a mental or emotional disturbance?

A. It is actually in the DSM IV, I would say it is an explanation for psychiatric disorders, it's a cause of them.

Q. Now, just to show you the school record again. You'll note the grade column, you'll see K, 1, 2, 3. And then beyond that you'll see notation for SP, SP, SP. Assuming that that SP means special education, following the third grade through the duration of Mr. Rompilla's stay in elementary school, is special ed placement something that you would have found useful in your evaluation?

A. It certainly would be useful. It's something that would have been interesting to note in my evaluation.

Q. And I'll direct your attention also on the exhibit to June of '61. There's a notation for [31] what appears to be the Stanford achievement test. And you'll note that he was born in 1948, so he would have been about 13 years old in 1961. And at that time he was reading at the third grade level, his arithmetic was also at about a third grade

level. Is that information that you would have found useful in your evaluation?

A. Yes, it would have been useful.

Q. And again, because that's evidence of either organicity or potentially of organicity or potentially of an abusive background or dysfunctional family?

A. Well, it's certainly evidence of a cognitive deficit. What that means is that you have to find out what that means.

Q. Some possible explanations are organicity, would you agree?

A. That's one of the causes of deficit, you have to look into that.

Q. And another potential explanation is an abusive childhood. Is that right?

A. Again, on a list – I mean, it's a possibility. It doesn't mean that there is one.

Q. I understand. Now, did childhood fever – withdrawn.

[32] I'd like to show you another exhibit that was marked in the hearing, Doctor, and direct your attention – this is the 1976 transfer petition, I think it's been identified from the department of corrections.

MR. McINTYRE: The one that showed up in the clerk's file?

MR. WISEMAN: That's right.

Q. You'll notice a scoring here for the wide range achievement test.

MR. NOWLAS [sic]: Let me just jump in for a minute. Do you have a number for it?

MR. McINTYRE: No.

MR. WISEMAN: I don't have it.

MR. NOWLAS [sic]: I'm sorry, I apologize.

Q. You'll see scoring for the wide range achievement. And just so you have some context for this, Doctor, this was testing that was done in 1976 upon Mr. Rompilla's entry to prison for a prior conviction. You'll see a reading score, spelling and arithmetic. And you'll see the percentiles at the end. There is a fourth percentile score on spelling, in the third percentile score in arithmetic. Is that information that you might have [33] found useful in your evaluation?

A. Yes, it would have been interesting to note that.

Q. And, again, that relates back to the school records we just discussed in terms of the reasons you'd find it of interest. Is that right?

A. Well, again I, would find it interesting because it gives you more of a picture of who you're dealing with. If the person is a slow learner, that is something that a psychiatrist should note. Again, I wouldn't infer that he was abused from that but, you know, that's your inference, not mine.

Q. Well, I wasn't making an inference, I'm just asking.

A. Again, for a complete evaluation that is something that is always important to know.

Q. Taking this wide range achievement test in conjunction with the school records we went through, would you explore it if you would have had the information and why?

A. Again, given my evaluation, rereading that and given what I was asked to do, I think I answered the question that the attorney asked me in terms of what was his mental state at the time of the alleged crime. And, again, if you read my [34] report, he said he didn't do anything wrong. He may have been drinking, and he denied having any disturbing pattern of thought or behavior on that day.

Having heard that and having been convinced that what he was telling me was reasonable, I didn't see any reason to go any further at that time. Except with the possibility that the alcohol may have caused him to be violent, may have an implication in a violent reaction. I mean, that's basically what my job was at the time as I understood it.

MR. WISEMAN: If we could take a three minute break, we might be approaching our conclusion. If that's all right with you.

(A brief recess was taken.)

Q. We're almost done here. Thinking back to the time of your evaluation, do you have any recollection as to whether or not Mr. Rompilla's attorneys asked you to determine if his ability – if his capacity to conform his conduct in the requirements of law was substantially impaired?

A. I don't recall that.

Q. If that was something you had been asked to look into, would that be contained in your [35] report?

A. Most likely I would have said that in my report.

Q. Do you recall if they asked you to look into the question of whether he had an extreme mental or emotional disturbance at the time of the offense?

A. Well, I was asked to determine his mental state. I would take that to determine whether he suffered from a psychiatric or organic or physical problem at the time.

Q. Do you recall if his attorneys asked you to look into social and developmental issues?

A. No. I don't recall that being asked at the time.

Q. Do you recall if they asked you to look into the existence or the absence of any mitigating factors at all in this case?

A. I don't think they asked me to do that.

Q. Again, if they had asked you that, it would have been in your report?

A. It would have been mentioned in the report, that's correct.

MR. WISEMAN: I have nothing further. Thank you, Doctor.

* * *

[36] CROSS-EXAMINATION

BY MR. McINTYRE:

Q. Doctor, just a few questions.

A. Okay.

Q. Did you have a file on Mr. Rompilla, an actual file?

A. I looked for one, I didn't have it. No, I don't have a file.

Q. Did you ever find a cover letter from his lawyers at that time?

A. We looked and couldn't find it.

Q. Back in 1988, this examination or evaluation took place in June, would it have been the norm to have gotten a cover letter from the lawyer representing the person prior to you doing an evaluation?

A. Well, it may not have been in '88. I must get one now, it changed. But it may have been that it was a phone call kind of thing at that time, a request or it may have been a letter. I think it varied back then.

Q. Is it fair to say that since about eight years have passed, it destroys your recollection?

A. That's correct.

[37] MR. McINTYRE: Let's have your report marked along with your notes in case you haven't done it before.

MR. WISEMAN: It has been marked.

MR. McINTYRE: Anyway, we'll call it Gross 1 for purposes of this deposition.

MR. WISEMAN: That's fine.

(Gross Exhibit Number 1 was marked for identification.)

Q. Did you look at your notes?

A. Yes.

Q. And did you compare it with the typed report?

A. Yes.

Q. Is the typed report accurate?

A. Yes, it is.

Q. You mentioned that you didn't think you had anything other than what Mr. Rompilla told you, and you probably didn't. But I'm looking at page 2, the first full paragraph where he relates a history of a prior charge. All those things came from Mr. Rompilla? I mean, it seems to be exact dates there and everything. Is it possible that that could have come to you from someone else?

A. It's certainly possible I could have [38] that. In fact, the exact date would lead one to think that I had some kind of documentation. The patient would most likely not remember an exact date.

Q. All right. And how about two, three, four paragraphs down, there is no history of any psychiatric illness or treatment for Mr. Rompilla. Does that indicate anything to you like you could have gotten that from him or does it seem like you got that from someone else?

A. That would seem like I would have gotten it from Mr. Rompilla himself.

Q. All right. Now these two exhibits that you were shown today, one was an initial transfer petition, and the other was the school records. If you had had them at the time that you did your evaluation, would they have affected the evaluation that you did, the result that you came up with?

A. Again, I was asked to do something that I thought I did. And I don't know that I would have done anything more. I don't think I would have done anything more than I already did at that time.

Q. As the defense attorney showed you those exhibits, did you see anything that would have affected the opinion that you rendered back in June [39] of 1988?

A. I don't see anything that would have changed my opinion.

Q. And basically, if I can paraphrase it, your opinion was although there was some evidence of antisocial behavior?

A. Yes.

Q. There was no other evidence for underlying psychiatric or mental disorder?

A. That's correct.

Q. And then you did say the possibility does remain, however, that Mr. Rompilla, while under the influence of alcohol, can become prone to violent behavior?

A. That's correct.

Q. Do you remember what the basis – can you tell from reading your report what the basis of that is? That because anybody who drinks, the drinking may cause some violent behavior?

A. Well, I think that in this case he obviously was in bars the day of the alleged crime, the murder, and drinking something. And I know as a psychiatrist that there is a condition that people can go kind of half crazy on alcohol and become very violent, things they would do under the influence [40] they wouldn't do not having been drinking. So I think I just kind of raised that as a possibility.

Q. As you would for anyone who had a history of drinking?

A. I did not have any evidence that it happened, but just as kind of a general hypothesis that that can happen, it's a possibility.

Q. Let me ask you this, I shouldn't let the curiosity get the better of me. How would you check that out, is there anything someone can do to check that out psychiatrically?

A. You get a history, because if there's a pattern, if it's happened once, it's going to happen again. So if someone drinks, you kind of get a corroboration in the history. And if you're really bold, you could challenge him with a couple of drinks and see how his behavior changes. I don't think under the circumstances with a guy in prison you would have done that. So I think what I would have done was try to get a previous history of any episodes that would have a bearing on this.

Q. Is there any diagnostic tests that you could do for that?

A. No. It's a clinical observation.

Q. You did a standard MSE, back in June of [41] 1988?

A. That's correct.

Q. And you were doing them at that time?

A. Yes, that is correct.

Q. And you were doing them for other people that would have been accused of murder?

A. That's correct.

Q. Back in 1988 had you ever been hired to do the kind of thing that the defense attorney asked you to do concerning mitigation, presenting a mitigation defense for a person accused of murder?

A. No, I did not. No, sir.

Q. Was that commonplace back in 1988?

A. I don't believe so, not in Lehigh County anyway.

Q. Now, you understand that it's more commonplace now eight years later?

A. Yes.

Q. In fact, I think a famous attorney wrote a book called The Abuse Defense?

A. That's correct.

Q. And we're more and more developing that today?

A. That's correct.

Q. But as you recall, you were not asked to [42] do that back then and that was not commonplace to do that?

A. That's right.

Q. Have you ever worked in tandem with a psychiatrist by the name of Gerald Cooke?

A. I am familiar with his work and I have used some of his reports in helping clients from time to time. We never really worked as a team, however.

Q. Do you know whether or not when you were retained for evaluation Dr. Cook was also retained for what he did? And a doctor, I believe it's Norm Sadoff, retained for what he does, do you know that?

A. In this case?

Q. Yes.

A. I don't know that at all.

Q. Is it possible that that happened?

MR. WISEMAN: Objection, he doesn't know.

MR. McINTYRE: You may answer.

A. It's certainly possible. I didn't know about it, but it's certainly possible.

MR. McINTYRE: I think I just have a few more questions. In fact, I don't have any, thank you.

[43] MR. WISEMAN: Just a couple follow up, Doctor.

* * *

REDIRECT EXAMINATION

BY MR. WISEMAN:

Q. Do I understand correctly then that your evaluation in 1988 was to cover competency to stand trial, is that something that you were concerned with?

A. Not in this report. I would have mentioned that actually if I was specifically asked to do that.

Q. So then you were looking at either sanity and/or diminished capacity?

A. Well, again, they were not specifically asked or otherwise I would have mentioned that in my first paragraph in terms of what was asked of me. Really, it was just determination of mental state at that time. There were many times I was asked to comment on what the mental state was at the time of the crime, those were often the kind of directions I got.

Q. And mental state at the time of the crime would include sanity, whether a person

A. It could include insanity.

[44] Q. It would include diminished capacity, whether they could form the intent to commit first degree murder?

A. Yes.

Q. That's where the alcohol blackout comes into play. Is that right?

A. That's possible, yes.

Q. But clearly you were not asked to do any kind of mitigation workup as we have discussed tonight?

A. That's correct.

Q. Now, had you been asked to discuss in your report and your evaluation mitigation, would the records I showed you – I think you said the records I showed you might have been useful to you in doing that type of an evaluation?

A. I think they would have been, if that were the question at the time.

Q. In determining the alcohol issue, either in regard to diminished capacity or as potentially a mitigating element in this case, would a family history of drinking have been something that you would have wanted to know about?

A. Yes. For those two questions, yes.

Q. That would include siblings, parents?

[45] A. I think alcohol in anybody in the immediate family would have been important to know.

Q. If I could just show you one more thing, I think we will be through. In the exhibit that I showed you that contained the WRAT scores, you'll see an MMPI scale?

A. Yes.

MR. McINTYRE: Which one is this? For the record, is that the transfer, the initial transfer petition?

MR. WISEMAN: Yes. I'm sorry, I didn't mention that.

Q. I don't mean to be disrespectful, but you're a psychiatrist not a psychologist, do you know how to read one of these?

A. I know the basics of this.

Q. Is that scale and that score in front of you, is that something that would have added to your evaluation at the time in 1988?

A. I think there's some elevated scales, that's always important to know when you're evaluating the mental status of a person. So, yes, it would have been interesting to note that.

Q. Which scales?

A. Here's 100, I think it's a personality [46] disorder scale. There's a paranoia scale, which is 80.

Q. There's a schizophrenia scale?

A. Yes, schizophrenia, which is 90. There's hysteria which is 82. So there's some elevated scores which are certainly abnormal. This is an abnormal MMPI.

MR. WISEMAN: Nothing further, thank you.

MR. McINTYRE: No further questions. I assume that his report and notes are in?

MR. WISEMAN: They're in.

(Deposition concluded 7:20 p.m.)

[47] April 11, 1996

I hereby certify that the evidence and proceedings are contained fully and accurately in the notes taken by me of

the testimony of the within witness who was duly sworn by me, and that this is a correct transcript of the same.

/s/ Mona Denise Ventresca
Mona Denise Ventresca
Registered Professional Reporter
Notary Public

The foregoing certification does not apply to any reproduction of the same by any means unless under the direct control and/or supervision of the certifying reporter.

Gross #1

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Attorney Maria L. Dantos
Public Defenders Office
Lehigh County Courthouse
Allentown, Pa. 18101

RE: Ronald Rompilla

Dear Atty. Dantos,

I have had the opportunity to evaluate Ronald Rompilla, a divorced forty year old man, per your request. The purpose of this evaluation is to determine Mr. Rompilla's mental state during the time of the alleged charges. He is charged with criminal homicide and related charges including burglary and receiving stolen property. This report is based upon an evaluation conducted at the Lehigh County Prison, on June 4, 1988.

He is charged with murdering a man who was the owner and bartender of a local tavern, on January 15, 1988. Allegedly, the victim was stabbed to death and the knife in question had part of his thumb print on it. In addition, there was a footprint which matched Mr. Rompilla's foot, found at the murder scene. Mr. Rompilla denies the charges entirely.

On the day of the murder, Mr. Rompilla spent the beginning of the day with his brothers, working as a painting contractor. He left work at lunch time and went to visit several local bars near his home. He returned to his house at dinner time and then went out after supper again, to some local taverns. He was at the scene of the murder, in a bar called the Kozy Korner, staying there until closing time at 2:00 a.m. He said that Mr. Scalon, the owner, let him out at that time and he recalls that there were four people left in the bar. Following this, he ate at a local diner, tried to get into his brother-in-law's home which was locked and then proceeded to find a room in a local motel, having been driven around Allentown for half an hour in a cab.

He does not recall the exact amount of alcohol that he had, nor does he feel that he was intoxicated during that night.

He did not have any motive, according to Mr. Rompilla, to want to hurt the victim. He said he was always on good terms with him.

Mr. Rompilla's past history is significant in that he was incarcerated for fourteen years on charges of rape, burglary, simple assault and escape. He was released on September 29, 1987 and was on parole since then. He spent his time reuniting with his family, working for his brother and he felt he was getting his life back in order.

He does admit to drinking, although not a great amount which was a parole violation. When asked why he did so he replied, "I was in jail for fourteen years, I wanted to live a little".

He denied drinking heavily or regularly. He said he drank on weekends and does not consider himself an alcoholic. He did, however, attend AA while he was in prison. He denies any periods of blackouts, medical problems from his drinking or driving while he was intoxicated. He also denies that alcohol made him do any violent behavior.

As far as drug use is concerned, he uses marijuana occasionally and denies any other hard drugs. When asked if he takes medication of any kind, he replied, "No, I respect my body".

There is no history of any psychiatric illness or treatment for Mr. Rompilla. He has not spoken to a psychiatrist except for a brief interview prior to parole. He has no history of any medical or surgical problems. He has never been in the hospital. He denies any head injuries.

Mr. Rompilla's childhood was uneventful. He was born and raised in Allentown, by his natural parents. His father is alive and his mother is deceased from cancer, two years ago. He is one of nine children. He denies any abuse, physical or sexual, while growing up. He left school in ninth grade because he wanted to work. He says he can read and write.

He started getting into trouble with the police at age fourteen or fifteen. Since 1964, he has been in and out of jails, detention homes, etc. His earlier charges were theft, car theft and burglaries. His most serious charge prior to

this charge was that of rape, which he totally denies and feels that he was "set up by the police".

He is not a formally religious man. He says he believes in religion, "my own way", that he watches Billy Graham on television for inspiration. He has been close to his son since he was released from prison and has a good relationship according to Mr. Rompilla, with his ex-wife. He also says that he is getting support from his father and some of his siblings.

On mental status exam, Mr. Rompilla presents as a calm and approachable forty year old man, who is well muscled and in apparent good physical shape. He seemed open and relaxed during the interview. He did not seem to be purposely holding back on any information during our discussion. He denied the charges and said that he is hopeful that it will be cleared up at the time of trial. He feels that people are judging him on his past behavior and that he has straightened out many of his prior problems. There is no evidence during the interview of any thought disorder or affective illness. His affect is not depressed nor is there excessive anxiety. There is certainly no evidence for any psychotic feeling of hallucinations or paranoia. He is appropriately concerned and upset about his charges but says he can sleep at night, because he has peace of mind. He denies any serious alcohol problems, he says he enjoys it but is under control when he drinks.

In my opinion, although there is certainly a strong element of antisocial behavior in Mr. Rompilla, there is no other evidence at this point in my evaluation, for underlying psychiatric or mental disorder. The possibility does remain however, that Mr. Rompilla while under the

influence of alcohol, can become prone to violent behavior, although he himself strongly denies this.

My recommendation is that this area should be further evaluated before any definite conclusions are drawn.

Sincerely yours,

Paul K. Gross, M.D.

PKG/mwp

[Handwritten Notes Of Dr. Gross Omitted In Printing]

[1] IN THE COURT OF COMMON PLEAS
OF LEHIGH COUNTY, PENNSYLVANIA

COMMONWEALTH OF PENNSYLVANIA, Respondent, vs. RONALD ROMPILLA., Petitioner.	:	NO. 682-1988 HON. THOMAS A. WALLITSCH

Wednesday, April 3, 1996
Plymouth Meeting, Pennsylvania

Oral deposition of GERALD COOKE, Ph.D., held at the offices of Gerald R. Cooke, Ph.D., 4 East Germantown Pike, Plymouth Meeting, Pennsylvania, 19462, beginning at 5:55 P.M., before Lynne Bell Coale, Registered Professional Reporter, Registered Merit Reporter, and Notary Public.

Anthony Gravinese & Associates
Philadelphia, Pennsylvania
(215) 487-7750

[2] APPEARANCES:

LEHIGH COUNTY DISTRICT ATTORNEY'S OFFICE
BY: MICHAEL MCINTYRE
Lehigh County Courthouse
Allentown, Pennsylvania 18102
Representing the Commonwealth of Pennsylvania

PENNSYLVANIA POST-CONVICTION
DEFENDER ORGANIZATION
BY: MICHAEL WISEMAN, ESQUIRE,
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Representing Mr. Rompilla

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[3] INDEX

WITNESS

GERALD COOKE, Ph. D

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[4] MR. WISEMAN: The record should reflect we're here for a deposition of Gerald Cooke, Ph.D., in regard to post-conviction litigation in the Ronald Rompilla case.

The parties agree that objections to questions will be made on the record and objections will not be preserved, or reserved I should say.

. . . GERALD COOKE, Ph.D., having been first duly sworn, was examined and testified as follows:

EXAMINATION

BY MR. WISEMAN:

Q. Doctor, what is your occupation?

A. I'm a clinical and forensic psychologist.

Q. Directing your attention to 1988, did you have any involvement in the case of Commonwealth versus Ronald Rompilla?

A. Yes.

MR. WISEMAN: Could we have [5] marked as an exhibit a letter – I guess we're up to 19.

MR. McINTYRE: Wasn't this already marked as D-2?

MR. WISEMAN: You're quite right.

MR. McINTYRE: Or D-3, one or the other.

MR. WISEMAN: You're right, absolutely right. We will not have this marked.

BY MR. WISEMAN:

Q. What I'd like to show you, Doctor, is what has been previously marked in this case as Defendant's Exhibit 3 and ask you if you recognize it.

A. Yes. That's my letter to the Public Defender, Maria Dántos.

Q. In the Ronald Rompilla case?

A. Yes.

Q. Now, have you conducted a search of your files in regard to Mr. Rompilla?

A. Yes.

Q. And other than the letter I just showed you, do you have any other material with regard to this case?

[6] A. No. It's pretty standard in our office that, after three years, if there's nothing happening in the case or no reason to preserve it, we keep the report but we get rid of all the things in the file, just the matter of preserving space.

Q. Now, you were retained by the defense in this case?

A. Yes.

Q. What were you retained to do?

A. I was asked to do a psychological evaluation of Mr. Rompilla. And I don't remember the specific referral questions, since I don't have the rest of the file.

Q. What testing did you do in this case?

A. Okay. I can only tell you what I probably would have done, again, without the file. But it's a pretty standard procedure. I'd say I'm 99 percent certain I did it.

I would have given him an MMPI, I would have given him an Incomplete Sentence Blank, the Rorschach inkblot

technique, and any of the two or three subtests of the verbal subscale of the Wexler Intelligence – Adult Intelligence WAIS Revised, the WASR, W-A-S-R.

[7] Q. Do you recall if you did any neuropsychological testing in this case?

A. I know I did not, other than the fact that the two or three subtests of the WASR would be part of a neuropsychological battery, but certainly by themselves would just constitute a rough estimate of intellectual function.

Q. I'd like to show you what's been marked previously in this case as Defendant's Exhibit 8 and direct your attention to the middle of the first page of the exhibit.

A. Yes, I see that.

Q. Now, in particular, directing your attention to the IQ testing conducted in 1957, the verbal score of 75; and, again in 1959, with a full scale of 64; and I turn the page and direct your attention to the 12/61 full-scale test score of 69.

A. I see it.

Q. What do those scores say to you as a clinical psychologist?

A. Well, they say to me that he was measured in the retarded to borderline range of intellectual functioning.

Q. Which tests show a retarded range?

[8] A. Well, anything below 70 would be considered to be the retarded range. So the verbal IQ of 75 in 1957 was borderline. The verbal IQ of 61 in 1959 would be considered retarded. Performance IQ of 75 would be

considered borderline. The full scale of 64 would be considered retarded.

Turning to 1961, verbal of 69 is retarded, performance of 75 is borderline, and the full scale of 69 is retarded.

Q. Now, the records I just put in front of you, did you have those records in 1988?

A. No.

Q. Generally speaking, when you see IQ testing in the range reflected in these records, what do you consider as a clinical psychologist? What's your next step?

A. My next step would be to conduct a full intellectual evaluation, what I call an organic screening. That is, I would use some quick measures that you can use in a prison setting that are part of the neuropsychological battery. Two of them are called Trails A and B. And, then, I might use the tapping subtest of the Raitan, R-A-I-T-A-N, battery.

Q. Now, when you say you do full intellectual [9] testing, what would that involve?

A. That would mean, instead of just doing two or three subtests of the verbal subscale of the WASR, I would give the entire test, which consists of five verbal scales and six performance scales.

Q. Is the –

A. I'm sorry, the other way around, six verbal and five performance.

Q. In the WASR the adult version of the WISC?

A. It is.

Q. Now, I take it from your answer that you would be looking into whether or not there's a genetic source for the low IQ testing.

A. That's taking it a step too far initially.

Q. Okay.

A. The first step would simply be to determine what the current intellectual functioning is. Then, based on that, I would use records and whatever additional testing I felt necessary to try and determine the reasons why an individual had a low IQ.

Q. What are some of the potential reasons why someone would have a low IQ?

A. There are a lot of possible reasons.

One is simply the normal bell curve, [10] they fall at the lower end. Another would be organic brain damage. Another would be emotional disturbance, because that can influence intellectual functioning.

So these are three general categories.

Q. When you say "emotional disturbance," are there causes that you would look for in terms of emotional disturbance?

A. Well, if you're talking about a child, I think you would look at the family situation, whether or not it was an abusive situation, a dysfunctional situation. You'd want to see more about the children's adjustment – the child's adjustment in school.

Q. Now, when you say, "If it's a child," would that be the case if you're looking at childhood records of an adult?

A. Yes. That's what I meant by, "if it's a child." If the scores were obtained when that person was a child, you'd want to find out what was going on when the person was a child in order to sort out the possible reasons.

You'd also get historical information: You know, what was the – including, Was the pregnancy difficult? Were there any abnormalities? things of that nature.

[11] Q. Why would you specifically do organic neuropsychological screening, given these particular test scores?

A. Well, because one of the alternatives would be an organic brain syndrome, which is now called a cognitive disorder. It's a change of terminology.

I would do the screening to see if there was anything that would suggest that it was organic rather than one of the other causes. And if I found on the screening that the person was impaired, then I would want to go on and do the full battery, the full neuropsychological battery.

Q. And, again, that screening would be Trails A and B, would include Trails A and B?

A. Yes, and the Raitan tapping test, usually, I use. But there are, then, six more Raitan tests that you would use if you went on to do the full neuropsyche battery.

Q. Now, if you were to administer the Trails A and B and the person came up on that as impaired, would that have caused you to do the full neuropsyche battery?

A. Again, I'd want to look at the overall pattern. I'd want to look at the pattern of scores [12] within the intelligence test; I'd want to look whether there was impairment on Trails and/or on the tapping.

One thing by itself wouldn't necessarily. But if those three things were pretty consistently pointing in the direction of organicity, I'd want to do the full battery.

MR. WISEMAN: I actually don't have much more. I just need one moment to talk with my colleague, if that's all right.

MR. McINTYRE: Sure.

(Discussion off the record.)

BY MR. WISEMAN:

Q. I want to show you another exhibit, Doctor, which has been previously marked in these proceedings as Defendant's 7. Just to give you the context, these are test results that were administered in 1975 to Mr. Rompilla. I'd like to direct your attention to the WRAT scores, W-R-A-T, at the left of the exhibit.

A. Right.

Q. What do those WRAT scores tell you about Mr. Rompilla?

A. Well, he was low average in reading, but he would be considered developmentally delayed in terms of [13] his spelling and arithmetic scores.

Q. And are those WRAT scores consistent with a learning disability?

A. Yes.

Q. And what is the interrelationship between learning disability and organicity?

A. There may or may not be one.

Learning disability can occur independently of organicity, or it may be due to and a function of organicity.

Q. If you were presented with someone who had these scores, would you consider organicity as a potential cause for those scores?

A. Definitely.

Q. Is there an interrelationship or relationship between learning disability and abuse as a child?

A. That's an interesting question.

Again, often children who do not come up to grade level, the reason is some sort of dysfunctional family situation and/or abuse. But there can be many other reasons, as well totally – there are children with learning disabilities who come from wonderful families. So it's one possible cause.

[14] Q. Is that something, given the WRAT scores, that you would want to explore in this case?

A. Again, once you're aware that there are some sort of intellectual or cognitive deficits, it's helpful to try and sort out the reasons for them as part of your understanding of the individual and how that bears on a legal case.

MR. WISEMAN: Doctor, I have nothing further. Thank you.

EXAMINATION

BY MR. McINTYRE:

Q. I have some questions for you, Doctor.

A. Sure.

Q. First of all, we skipped qualifications entirely. Let's get a little bit on the record about your qualifications.

A. Do you want me to give you a CV?

Q. Yes. Do you have that? We can get that later on.

Now, let me ask about your experience back in 1988.

Were you doing these MSEs a lot back [15] then?

A. Okay. First of all, MSE really is what a psychiatrist does, a Mental Status Exam. The psychological evaluation includes an interview which parallels the Mental Status Exam but goes far beyond that in terms of the psychological testing.

The answer to your question is, yes, I was doing those – at that point I had been doing them routinely for over 20 years.

Q. And had you been doing them in capital cases, as well as other type of criminal cases?

A. Yes, as well as noncriminal cases.

Q. Had the Public Defender's Office of Lehigh County been – I don't know if it's correct to call them a

client – but one of the avenues for you to receive clients, through the Public Defender's Office?

A. Well, I don't remember specifically. They probably had retained me in prior cases.

Q. Okay.

A. But I don't remember specifically.

Q. Now, normally, you get a referral letter from the person such as the Rompilla's attorneys in this case, I take it.

A. Not necessarily. Actually, more often than [16] not, the first contact is by phone. And we would – we have something we call a contact sheet, where we write down the basic information, the basic – you know, the name of the person, the attorney, the nature of the case, the kinds of questions and issues that are at hand.

Q. If there was such a thing in this case, it would have been thrown out after three years of inactivity?

A. Yes.

Q. I take it you have no actual recollection of this particular case? Or do you?

A. Vaguely. Not really any specificity.

Q. You went up to Lehigh County Prison and interviewed Mr. Rompilla?

A. Yes.

Q. And tested him there?

A. Yes.

Q. Do you know exactly what you were asked to do by the Public Defender's Office?

A. No.

The reason is, in addition to just the sort of referral for psyche evaluation, I will usually spell out with the attorney, Is there an initial [17] competency? Is there a question of insanity? Is the disposition – is it death penalty litigation? And I will go over that.

So I would have done that, but I don't recall what the answers were to those questions.

Q. All right. So there's no way for you to tell whether or not you did death penalty mitigation-type testing at that time?

A. Well, if I knew it was a death penalty case, which I believe I did, then, I would have – that would have been one of the questions in my mind: whether he showed any mental illness, emotional disturbance, or other sorts of problems that might be a psychological mitigating circumstance.

Q. What were the standard tests that you were doing back then in 1988 on that issue?

A. Well, the same battery of tests I mentioned before.

Q. All right. The MMPI?

A. Right.

Q. Rorschach?

A. Yes.

Q. Incomplete Sentence and the Wexler?

A. Well, just some subtests of the Wexler [18] initially, unless I found something that would make me pursue it.

Q. All right. I get confused on these things. The Wexler is an IQ test?

A. Yes.

Q. And if he had produced – if his results were in the mentally-retarded area from your test, would you have followed that up?

A. Yes.

Q. All right. And you would have followed it up in the way that you explained on direct examination today?

A. What I would have done, if I had gotten mentally-retarded scores on the subtests I gave him, I would have gone on to give the full IQ test, at the very least, and, then, probably a couple of organic screening [sic].

The problem there is, I would have already been there without the organic tests. I would have had the full Wexler with me. I would have gone on and done the full IQ test. And, then, if I found anything suspicious, I would have called the attorney and said, "I think we need to do a neuropsyche test."

Q. Is there any way we can tell, sitting here [19] now eight years later, that his test results were not in that mentally-retarded area, or they were and you did all these things?

A. Yes.

Q. We can?

A. Yes.

Q. Okay.

A. I know that I did not obtain scores in the mentally-retarded area at the time that I tested him, or I would have gone further. But I don't know exactly, you know, what those scores were.

Q. Okay. Now, do you have an opinion to a reasonable degree of psychological certainty as to which is more reliable: the test scores that you do or you did on this 40-year-old man in 1988, or on 30-year-old school scores – strike that – IQ scores that are in school records as produced by counsel today?

A. I don't think –

MR. WISEMAN: Objection to the form.

BY MR. McINTYRE:

Q. You may answer.

A. I don't think you can talk about reliability [20] per se.

Assuming they gave the full WISC, which is – and I only give part of the WAIS, actually, their scores would be more reliable than the ones I obtain, because I only gave part of the test.

But intellectual functioning at any given point in time is a function of many factors, and you would have to look at the variability among the different subtests to know what factors were leading to problems.

Q. Back in 1988, was it a standard for you to obtain school records of people such as Mr. Rompilla?

A. That depended.

What I would do when first talking with the attorney would be, among other questions, ask them if there was any reason for them to believe that their client was retarded or had organic brain damage or anything of that nature. That would have been a standard question.

Again, I can't swear to you that I said that, but I'm 99 percent sure I would have because that's part of the checkoff list always. When the evaluation comes in, I want to know whether I'm doing a psyche evaluation or a psyche – neuropsyche [21] evaluation. So I would almost always ask that question.

Q. Are you able to say right now, not having the scores that you got from your own IQ tests, whether or not, if you had the school results, whether you would have done anything differently?

A. Yes, I am able to say that.

With the school results, I would have definitely given the full IQ test.

Q. No matter what yours were?

A. No matter what those three were, because there could be marked differences. That would have been a red flag and that would have been something I would have pursued.

Q. On D-7, which were these prison record scores, you looked at the WRAT tests here.

Did you give any tests that would be similar to a WRAT?

A. No.

Q. All right. Also on that, do you see the Beta IQ score of 93 –

A. Yes.

Q. – average? I guess that puts him somewhere in the average?

[22] A. That does.

Q. If you had gotten that or if you had that, would that have made you do any more testing at all?

A. You mean –

Q. If you had had this record at the time of your testing.

A. Just this record?

Q. Yes.

A. Well, I would have been concerned about the spelling and arithmetic and would have gone back to the attorneys and said, you know, "Is this guy a special education?" "Did he have developmental problems?" and so on.

The Beta is a very iffy test. It's a very quick screening device. It takes about 15 minutes, and it involves only performance IQ, not verbal IQ. It is much less reliable than things like the WISC or the WAIS or other full IQ tests. So that wouldn't move me one way or another.

But the spelling and arithmetic scores would concern me.

Q. The tests that you did do, the four that we talked about, were those in conformity with the accepted standards at that time for psychological [23] evaluation?

A. Sure.

Q. Do you recall any results of – particularly, the MMPI, do you recall –

A. I can't –

Q. – anything about that?

A. I can't give you specifics. I don't remember what the profile was or – at all.

Q. All right. You wouldn't be able to recall whether or not, based on the MMPI scores, Mr. Rompilla was found by you to be a sociopath?

A. I can guess from my letter – and that's all that I'm doing – that I did not find any, you know, major mental illness that would have been a mitigating factor. I can't go much further than that.

Q. All right.

A. He might have been some sort of personality disorder, but I can't say specifically that it would have been what we called sociopath then, what we call now antisocial. It might have been any one of a number or a mixture.

Q. Sociopath now is called antisocial personality?

A. Disorder.

[24] Q. A disorder, right.

You mentioned that there were a lot of different reasons why a person could have a low IQ.

A. Yes.

Q. Are any of them rectifiable?

A. Sure.

Q. All right. I take it if there was some emotional problems at the time, that might result in a low IQ in a child, but, later on, if he got out of that environment, his IQ could rise?

A. That's fair, yes.

Q. There's no way for us to know whether or not your test results of Mr. Rompilla's IQ indicated a higher score because of the change in his life or a change in his life?

A. I don't know what I thought back then. But, of course, I didn't have the comparison, so there's no way to know.

Q. Do you remember whether or not the Public Defenders, Miss Dantos or Mr. Charles, showed you a report from Paul Gross that was done in June of 1988?

A. I don't remember.

Q. All right.

A. Again, I don't list what records I reviewed. [25] Had I done a full report, I would have.

Q. And you worked with Robert Sadoff, Dr. Robert Sadoff, occasionally, didn't you, back then in 1988?

A. Yes. Still do, occasionally.

Q. Do you know that he was brought into this case as well? Did you know that?

A. I don't recall.

Q. Nothing in your file indicates that?

A. Again, I only have the one letter.

I don't think he's CC'd on that. I don't know.

Q. That letter that you're looking at from you, is there a reason why you didn't issue a report, or was there a reason back then that you didn't issue a report every time you did a psychological evaluation?

A. Yes. I always convey the findings verbally first, and then I leave it to the attorney whether they want a report or not.

In this case – and I know because I know what it means when I generate that kind of letter – I didn't have anything that I felt could be helpful, and they just wanted simply a letter that could document that I saw him for the file, and that's [26] what they got.

MR. McINTYRE: All right. I have no further questions. Thank you, Doctor.

MR. WISEMAN: Just a couple follow-up, Doctor.

EXAMINATION

BY MR. WISEMAN:

Q. You mentioned on Mr. McIntyre's exam about special education.

Is special ed also the kind of red flag that would cause you to – a history of special education the kind of red flag that would have caused you to look towards organicity?

A. Well, again, it would have certainly caused me to investigate further, and that would have been one of the possible things I would be looking for.

Q. Now, on the Beta exam, in your experience, do the people tend to score higher or lower or about the same on a Beta as they do on a WAIS?

A. It depends on the type of person. But, by and large, they tend to score high.

Q. Do you have any estimate in your mind of how [27] much higher?

A. Frankly, I don't know anybody who's used the Beta except in an institutional setting, like in a state mental hospital or prison, where you want to do a lot of people quickly. You can do it with ten people in the room, that kind of thing.

I don't know anybody who would use it on a routine basis in an individual practice.

Q. Now, when you were asked on direct about what you would do to screen for organicity, you talked about a full IQ and you would do two screening tests, Trails A and B, and the finger tapping and Raitan.

A. Right.

Q. On cross-examination, I think you said you'd do a full IQ.

Did I mishear you or did you –

A. I think the question was somewhat different, as –

Q. Oh, was it?

A. – I recall. I mean, I think, basically, I don't remember the context of that question.

Q. Okay.

A. It may have been that if my scores had come out in the retarded range, what would I have done, and [28] I would have gone on to do a full IQ. Then, if the pattern on the full IQ, along with records that I didn't have, suggested organicity, I would start – I would do the organic screening.

But I think what I mentioned is I would not have gone prepared to do a neuropsyche. So I would have finished the IQ, called up the attorney, and said, "Look, I think there's organicity here, it's your call. Do you want me to go back and conduct the full neuropsyche battery?"

Q. Is an MMPI a neuropsychological test?

A. No.

Q. Is sentence completion neuropsychological?

A. No.

Q. Just so the record is clear, do you have any test results at all in your file at this point on Mr. Rompilla?

A. No.

Q. Do you recall counsel giving you any specific instructions at all or any theory of mitigation or any specific testing requests?

A. I don't recall.

As I say, if I knew it was a death penalty case – and I believe I did – I'm familiar with [29] the mitigating factors in a death penalty case, and I would have considered those in the process of my evaluation. But I don't know that they specifically gave me anything.

Q. In your experience as a forensic psychologist who's worked on capital cases, is organicity a mitigating factor that you've testified about in these cases?

A. Yes. It is a mental defect that certainly qualifies as a mitigating factor.

Q. How about child abuse; is that a mitigating factor?

A. That sort of comes in under the "other."

It often helps explain, certainly, to a jury how the person got to where they are, why they are the types of people they are, and it's then up to a jury to consider whether that's a mitigating factor or not. But that's certainly – where I find a history of abuse, that's certainly something that is a possible item to be presented.

Q. When you say "other," are you referring to the catchall mitigator?

A. Yes.

Q. Now, in your experience, is child abuse [30] sometimes a causative factor for emotional disturbance?

A. It certainly can be, yes.

Q. And, in that sense, could child abuse with a resulting emotional disturbance be one of the mental-health mitigators under the statute?

A. Well, that would depend if it met the specific mental health, you know, criteria as stated. So it might or might not.

Q. And, finally, I don't have the document with me, but there is evidence in this case that Mr. Rompilla scored a 79 on WAIS in 1988 after the trial proceedings when he was admitted to the Department of Corrections.

Assuming for the while that that score is in the ball park of what he would have scored on the WAIS, had you given him one in 1988, is that the type of score, with the other information we've discussed, that would have caused you to look at organicity?

A. With the other information in the records that I didn't have, yes. By itself, not necessarily.

MR. WISEMAN: Okay, nothing further.

MR. McINTYRE: I have no further questions. Thank you, Doctor.

[31] (Witness excused.)

(Discussion off the record.)

MR. WISEMAN: Counsel and I have had a discussion off the record and have agreed that defense counsel will provide to the Commonwealth a copy of the 1988 WAIS, W-A-I-S, score as reflected in the Department of Correction records, and we will forward it to the court reporter to be marked as Exhibit 20. I believe it's a one-page exhibit. It might have two pages.

Anything else?

MR. McINTYRE: No, that's fine.

(Exhibits 19 and 20 marked for identification.)

(Proceedings adjourned at 6:35 P.M.)

[32] CERTIFICATE

I HEREBY CERTIFY that the proceedings, evidence, and objections are contained fully and accurately in the stenographic notes taken by me upon the deposition of GERALD COOKE, Ph.D., on Wednesday, April 3, 1996, and that this is a true and correct transcript of same.

/s/ Lynne B. Coale
Lynne Bell Coale, RPR, RMR,
and Notary Public

(The foregoing certification of this transcript does not apply to any reproduction of the same by any means, unless under the direct control and/or supervision of the certifying reporter.)

NAME ROMPILLA, Ronald NUMBER S-2057 DATE 12/9/88

STABILITY 3 INTELLIGENCE RATING: Low Average

PSYCHIATRIC HISTORY:

None reported.

PSYCHOLOGICAL REPORT:

Test Administered:

1. Revised BETA II Examination
2. Jastak Wide Rage Achievement Test (WRAT) Reading Only

READING SCORE	40	S.S.	67	PERCENTILE	1	G.E.	58
SPELLING SCORE		S.S.		PERCENTILE		G.E.	
ARITHMETIC SCORE		S.S.		PERCENTILE		G.E.	

3. Bender-Gestalt
4. Projective Drawings
5. Minnesota Multiphasic Personality Inventory (MMPI)

SCALE:	?	L	F	K	Hs	D	Hy	Pd	Mf	Pa	Pt	Sc	Ma	Si
T-Score														

(K Corrected Where Applicable)

1082

OTHER: WAIS Digit Span, Similarities: 79

ANALYSIS OF INTELLIGENCE AND INTELLECTUAL FUNCTIONING:

Mr. Rompilla earned a WAIS Score of 79. This score falls within the borderline range of the mental ability according to the Beta II classification. The obtained rating is not viewed as a reasonably accurate estimate of his intellectual potential. Mr. Rompilla is housed in the RHU as a capital case. Therefore he did not take the usual diagnostic battery. Beta testing on file from 1975 and 1976 indicates low average intelligence.

ANALYSIS OF PERSONALITY MAKE-UP:

This is a 40 year old inmate who states that he was paroled from SCI-Huntington in 9/87 after serving about 14 years in jail for rape and escape. He begins today's session by announcing: "My lawyer advised me not to say anything; they're supposed to get me off death row." Told the purpose of this interview he responds: "I've been examined by psychiatrists (for reasons related to the present case) and I'm okay."

EXHIBIT 19

GERALD COOKE, Ph.D. &
MARGARET COOKE, Ph.D., P.C.
CLINICAL AND FORENSIC PSYCHOLOGY
LICENSED PSYCHOLOGISTS
4 EAST GERMANTOWN PIKE
PLYMOUTH MEETING, PA 19462

GERALD COOKE

CURRICULUM VITAE

PRESENT POSITIONS

Private practice in Clinical and Forensic Psychology. Forensic Psychodiagnostic Evaluation, Neuropsychological Evaluation. Consultation with attorneys, court testimony, Psychotherapy.

Consultant, Norristown State Hospital Psychology Department – Forensic and Neuropsychological Evaluation; 1978 to present.

Lecturer in Law and Psychiatry, Villanova University Law School, January 1987 to present.

Psychological Consultant, Joseph J. Peters Institute (Psychological evaluation of alleged sex abusers); April 1993 to present.

Consultant, Philadelphia City Solicitors Office/Police Department: Revision of Psychological Screening Process to eliminate adverse impact on minority group members.

CERTIFICATIONS

Licensed Psychologist, State of Pennsylvania Number PS-001778-L.

Certified as an Instructor by the Municipal Police Officers' Education and Training Commission, Number MPI 1759.

Diplomate, American Board of Forensic Psychology, part Chairperson of the Board's Continuing Education Committee; 1979-81; Examiner for the Board, 1979-present; Regional Examination Chairperson, Northeastern U.S., 1982-83.

Diplomate, American Board of Professional Psychology.

EDUCATION

9/59 - 6/63	University of Chicago, Chicago, Illinois, B.A. Psychology.
9/63 - 6/66	University of Iowa, Iowa City, Iowa, M.A., Ph.D., Clinical Psychology.
8/66 - 8/67	Post-Doctoral Internship, Norristown State Hospital, Norristown, PA.

PROFESSIONAL MEMBERSHIPS

Fellow, American Academy of Forensic Psychology.

Member, American Psychological Association.

Member, American Psychology-Law Society.

Charter Member, Division of Psychology and Law, American Psychological Association.

Resource Professional, American Psychological Association Committee on. Legal Issues.

Member, Southeastern Pennsylvania Mental Health Association. Member, Division of Children, Youth and Family Service, American Psychological Association.

Member, Subcommittee on the impact on the legal System on Women, Montgomery County Commission on Women.

Member, Division of Clinical Neuropsychology, American Psychological Association.

GRANTS AND AWARDS

Visiting Scientist, American Psychological Association, 1972.

NIMH Small Grant MH22267-01, Analysis of the Non-Professional Therapist Program, 6/16/72 - 5/31/73.

NIMH Small Grant MH12195-02, Principal Investigator on a $9,000, three-year (1972-1975) grant to evaluate the Paraprofessional Training Program at the Salvation Army Harbor Light Alcohol Treatment Program, Detroit, MI. Three-year continuing grant, 1975-1978.

Project Advisory Committee, $120,000 grant to the Forensic Sciences Foundation for a study of Utilization of Psychiatric and Psychological Assessments by Criminal Court Judges, 1980-1981.

Consultant, $57,000 NIMH Crime and. Delinquency grant for training CMHC personnel in Forensic Psychiatry/ Psychology, 1980-1982.

Meritorious Service Award, American Board of Professional Psychology, 1993.

PREVIOUS POSITIONS

1/68 - 6/71	Research Consultant, Hermann Kiefer Hospital and Sinai Hospital, Detroit, MI.

11/70 - 7/72	Group Leader of Black-White encounter groups of Police Officers, Detroit Police Department.
9/72 - 6/73	Group Leader of encounter groups on White supervisors and Black "new hires" for Detroit Edison and Michigan Bell Telephone.
1/68 - 8/73	Consultant and Acting Director of Psychology, Center for Forensic Psychiatry, State of Michigan.
9/67 - 9/73	Assistant Professor of Psychology, Wayne State University, Detroit, MI.
9/71 - 8/73	Consultant, V.A. Hospital, Allen Park, MI. Behavior Therapy, Forensic Psychology.
1/68 - 8/74	Private Practice, Detroit MI.
4/74 - 12/75	Psychological Consultant, State Correctional Institution at Graterford.
1976	Instructional Consultant, Bucks Count Department of Mental Health, Crisis Intervention Training Program for Police.
6/75 - 8/77	Clinical Evaluator of Juveniles for the Youth Services Bureau Project at the State Correctional Institution at Camp Hill.
6/71 - 7/78	Consultant, Detroit Salvation Army Alcohol Treatment Program.
8/73 - 12/78	Chief Forensic Psychologist, Norristown State Hospital, Norristown, PA.
1974 - 1979	Member of Norristown State Hospital Suicide Committee.

1/79 - 1/80	Consultant, Mental Health Advocates of PA.
12/78 - 4/81	Consultant, Norristown State Hospital Juvenile Forensic Unit.
1978 - 1994	Faculty, Continuing Education Program in Psychiatry. The Department of Psychiatry of the School of Medicine of the University of Pennsylvania; 1978 to 1994.
1/82 - 12/83	Consultant, Institute of Pennsylvania Hospital Neuropsychological and Forensic Evaluation.
1975 - 1985	Instructional Consultant, Temple University Center for the Administration of Justice. Selection and Training Programs for police departments; course in crisis intervention.
1981 - 1985	Affiliate Staff, Eugenia Hospital, Lafayette Hill, PA. Neuropsychological and Forensic Psychodiagnostic Evaluation.
1982 - 1989	Consultant, insight Centers – Professional Rehabilitation Services, Psychological-Vocational Evaluation.
1984 - 1988	Consultant, Placement Services, Inc. – Professional Rehabilitation Services, Psychological-Vocational Evaluation.
1989	Off Campus Clinical Practicum Supervisor, Department of Psychology, Temple University.

ARTICLES

1. Cooke, G. the Efficacy of Two Behavior Therapy Procedures: An Analogue Study. *Behavior Research and Therapy*, 1966, *4*, 17-24.

2. Boxer, A., Sadoff, R., & Cooke, G. the Court and the State Hospital: Model for a Therapeutic Relationship, Mimeo, 1967.
3. Cooke, G. Evaluation of the Efficacy of the Components of Reciprocal Inhibition Psychotherapy. *J. Abnorm. Psychology*, 1968, *73*, 464-467.
4. Cooke, G. The Court Study Unit: Patient Characteristics and a Comparison of Patients Judged Competent and Incompetent. *J. Clin. Psychology*, 1969, *25*, 140-143.
5. Chodorkoff, B. & Cooke, G. Development of an Inventory to Measure Psychosexual Development. *Psychol. Reports*, 1970, *27*, 186.
6. Cooke, G. & Chodorkoff, B. The Reliability of Classification of Behaviors within Psychosexual Stages. *Psychol. Reports*, 1970, *26*, 751-754.
7. Chodorkoff, B. & Cooke, G. The Attitudes of Medical Students Toward Mental Illness: An Abstract. *Proceedings of the 10th Annual Conference on Medical Education*, 1971, 183.
8. Cooke, G. & Jackson, N.L.P. Competency to Stand Trial: The Role of the Psychologist. *Professional Psychology*, 1971, *2*, 373-376.
9. Cooke, G. & Robey, A. The MMPI: A Case Study in Dissimulation. *J. Consult. Clin. Psychol.*, 1971, *36*, 355-359.
10. Cooke, G., Johnston, N. and Pogany, E. Factors Affecting Referral to Determine Competency to Stand Trial. *American Journal of Psychiatry*, 1973, *130*: 8, 870-875. Also in Messinger, et. al., (Eds) 1973 *Crime and Justice Annual*, Aldine, Chi.
11. Johnston, N. & Cooke, G. Relationship of MMPI Alcoholism, Prison Escape, Hostility Control and

Recidivism to Clinical Judgements. *Journal of Clinical Psychology*, 1973, *29*, 32-34.

12. Pierce, D., Cooke, G. & Frahm, P. Sort-Score Correlates of Schizophrenia *Journal of Personality Assessment*, 1973, *37*, 508-511.
13. Cooke, G., Pogany, E. & Johnston, N. A Comparison of Blacks and Whites Committed for Evaluation of Competency to Stand Trial on Criminal Charges. *Journal of Psychiatry and Law*, Fall, 1974, 319-337.
14. Wehmer, G., Cooke, G. & Gruber, J. Evaluation of the Effects of Training of Paraprofessionals in the Treatment of Alcoholism: A Pilot Study, *British Journal of Addiction*, 1974, *69*, 33-39.
15. Cooke, G. Manual for the Use of the MMPI in the Correctional System, Mimeo, 1975.
16. Cooke, G. Basic Helping Techniques, Mimeo, 1975.
17. Cooke, G., Wehmer, G. & Gruber, J. Training Paraprofessionals in the treatment of Alcoholism: Effects on Knowledge, Attitudes, and Therapeutic Techniques. *Journal of Studies on Alcohol*, July, 1975, *36*, (7), 938-948.
18. Cooke, G. & Sikorski, C. Factors Affecting Length of Hospitalization in Persons Adjudicated Not Guilty By Reason of Insanity. *Bulletin of the American Academy of Psychiatry and Law*. 1975, *2*, 251-261.
19. Cooke, G. & Pogany E. The Influences on Judges' Sentencing Practices of a Mental Evaluation. *Bulletin of the American Academy of Psychiatry and Law*. 1975, *3*, 245-251.
20. Gruber, J., Wehmer, G. & Cooke, G. Training Paraprofessionals in the Treatment of Alcoholism: Differences in Effects Due to Prior History of Alcohol and Drug Abuse. *British Journal of Addiction*, 1976, *71*.

21. Cooke, G. & Thorwarth, C. Prediction of Elopement of Mentally Ill Offenders Using the MMPI. *Criminal Justice and Behavior*, 1978, *5*, 151-157.
22. Cooke, G. Behavioral Treatment of Rapists. *The Prison Journal*, 1978, *58*, 47-52. Reprinted in *The Inventory of Marriage and Family Literature*, St. Paul; University of Minnesota, Vol. 5, 1979.
23. Cooke, G. Training Police Officers to Handle Suicidal Persons, *Journal of Forensic Sciences*, 1979, *24*, 227-233.
24. Cooke, G. The Role of the Psychologist in Evaluations of Criminal Competency and Responsibility, *Clinical Psychology*, Philadelphia Society of Clinical Psychologists, 1981.
25. Cooke, M. & Cooke, G. An Integrated Treatment Program for Mentally Ill Offenders: Description and Evaluation, *International Journal of Offender Therapy and Comparative Criminology*, 1982.
26. Male, T.C. & Cooke, G. The Psychologist and Joint Custody, in Pennsylvania Bar Institute, *Custody Update: The New Shared Custody Act and New Custody Rules*, Pennsylvania Bar Institute, 1982.
27. Dietz, P.E. Cooke, G., Rappeport, J.D. & Silvergleit, I.T. Psychojargon in the Psychological Report: Ratings by Judges, Psychiatrists and Psychologists, *Behavioral Science and the Law*, 1983.
28. Cooke, G. The Civil Competency Evaluation: Guidelines for Objective Assessment, *American Journal of Forensic Psychology*, 1985, *3*, 10-20.
29. Cooke, G. Psychological Evaluations in Child Custody Cases, in Pennsylvania Bar Institute, *Custody Update: Support, Witness and Discover*, 1987.

30. Cooke, G. Psychological Evaluation in Child Custody Cases in Pennsylvania Bar Institute, *Child Custody Litigation*, Harrisburg, PA 1990.

31. Cooke, G. & Cooke, M. Dealing with sexual abuse allegations in the context of custody evaluation, *American Journal of Forensic Psychology*, 1991, 9, 1-13.

32. Cooke, G. Legal Regulation of Child Sexual Abuse Evaluation and Testimony, *American Journal of Forensic Psychology*, Vol, 10, #4, 1992.

33. Cooke, G. Psychological Evaluation in Child Custody Cases, Pennsylvania Bar Institute, *Winning with Expert Witnesses and Discovery in Family Law Litigation*, Harrisburg, PA, 1994.

34. Cooke, G. The role of the mental health professional in harassment/discrimination cases: A moderate perspective, *American Journal of Forensic Psychology*, in press.

BOOK CHAPTERS

1. Cooke, G. Behavior Therapy with Stutterers, in E. Anderson, *Treatment of the Young Stutterer*. Wayne State University Press, Detroit, Michigan, 1969.

2. Cooke, G. Psychological and Neuropsychological Evaluation. Chapter in *Psychic Injuries* (M.E. Lewis, R.L. Sadoff, Eds.) Courtroom Medicine, Vol. 12, Matthew Bender, New York, Second Edition, 1978. (Five Chapters in the 1979 reprinting.)

3. Cooke, G. Legal Issues, Chapter in G. Tyron, (Ed) *The Professional Practice of Psychology*, Ablex, Norwood, NJ., 1986.

4. Cooke, G. Forensic Psychology; Chapter in *Wiley Encyclopedia of Psychology*, R.J. Corsini (Ed.), Wiley, NY 1984.

5. Cooke, G. Forensic Psychology, Chapter in Cyril H. Wecht (Ed.) *Forensic Sciences*, Matthew Bender, NY 1984.

6. Cooke, G. Parricide, Chapter in Owen, C.E. & Leibman, F.H. (Eds.) *Counseling Offenders: A New Perspective*, in press.

BOOKS

1. Cooke, G. (Ed.) *The Role of the Forensic Psychologist*. Charles C. Thomas, Springfield, IL, 1980.

BOOK REVIEWS

1. Cooke, G. Book Review of Therapeutic Communities in Corrections by Hans Toch, in *The Journal of Psychiatry and Law*, Fall, 1981, 345-347.

2. Cooke, G. Book Review of Clinical Handbook of Psychiatry and the Law by Thomas G. Gutheil and Paul S. Appelbaum in *The Journal of Psychiatry and Law*, Summer, 1984, 285-288.

3. Cooke, G. Book Review of Advances in Forensic Psychology and Psychiatry, Vol. I, in *The Journal of Psychiatry and Law*, 1986.

4. Cooke, G. Book Review of Custody Disputes: Evaluation and Intervention, Edited by Ruth S. Parry, et al., in *The Journal of Psychiatry and Law*, Summer, 1987, 307-310.

5. Cooke, G. Book Review of Handbook of Forensic Psychology, Edited by Irving B. Weiner and Allen K. Hess, in *Contemporary Psychiatry*, 1988, 7, 1, 64-66.

6. Cooke, G. Book Review of Evaluating Children for the Courts using Psychological Tests, Edited by Stanley

Kissel and Nelson W. Freeling, in *The Journal of Psychiatry and Law*, Winter 1990. 453-457.

7. Cooke, G. Book Review of Assessment and Prediction of Suicide by Ronald W. Maris, et al., in *The Journal of Psychiatry and Law*, Spring 1994.

8. Cooke, G. Book Review of The Violence Prediction Scheme: Assessing Dangerousness in High Risk Men by C. D. Webster, et. al., *The Journal of Psychiatry and Law*, in press.

EDITORIAL CONSULTATION

Editorial Consultant, *Journal of Abnormal Psychology*, 1972-1973.

Consulting Reader, *Psychological Reports*, 1975.

Consulting Reader, *Journal of Studies on Alcohol*, 1975-1979.

Editorial Consultant, *Criminal Justice and Behavior*, 1976.

Subcommittee for Paper Selection, Eastern Psychological Association Convention, 1978.

Editorial Consultant, *American Psychologist*, 1979, 1980, 1982, 1987.

Consulting Reader, *Journal of Consulting and Clinical Psychology*, 1986.

CONVENTION PRESENTATIONS

1. Cooke, G. The Role of the Psychologist In Criminal Court Proceedings, Presented at the American Psychological Association Convention, Washington, D.C., 1976.

2. Cooke, G. The Role of the Forensic Psychologist in the Evaluation and Treatment of Offenders, Presented

at the Pennsylvania Psychological Association Convention, October, 1977.

3. Cooke, G. Behavioral Treatment of Rapists, Presented at the Conference, *The Faces of Rape*, January, 1978, Philadelphia.

4. Chairperson and Discussant: Panel on Forensic Criminal Psychology, Eastern Psychological Association Convention, Washington, D.C., March 1978.

5. Cooke, G. The Prediction of Dangerous Behavior, Presented at the Pennsylvania Psychological Association Convention, June, 1978, Lancaster, Pennsylvania. (Also participated as expert witness in a mock trial.)

6. Mugrauer, W. and Cooke, G. Crisis Intervention Training for Police Officers, Conference on Violence in the Family, Atlantic County Community College, NJ, August, 1978.

7. Mugrauer, W. and Cooke, G. Crisis Intervention Training for Police Officers, Police Training Conference, Pomona, NJ, September, 1978.

8. Cooke, G. The Role of the Expert Witness; Screening for Competency to Stand Trial, Presented at the Philadelphia Society of Clinical Psychologists Continuing Professional Education Program, December, 1978.

9. Cooke, G. Evaluation of Civil Competency under the Vecchione Decision, Presented at the Vecchione Workshop of the Philadelphia Bar Association, Philadelphia, May, 1979.

10. Cooke, M.K., and Cooke, G. An Integrated Treatment Program for Mentally Ill Offenders: Description and Evaluation, American Psychological Association Annual Convention, New York, 1979.

11. Cooke, G. Follow-up of Criminal Status of Persons Evaluated for Criminal Competence, American Psychological Association Annual Convention, New York, 1979.

12. Cooke, G. and Lewinn, L. Presentation of Psychological Evidence in Criminal Court Cases, Presented at the Fall Conference of the Pennsylvania Psychological Association, October 26-28, 1979.

13. Cooke, G. Presentation on Mental Illness, Philadelphia Bar Association Training Seminar on Mental Disabilities, Philadelphia, March, 1980.

14. Mugrauer, W. and Cooke, G. Crisis Intervention Training for Police Officers, at the Conference on Violence and use in the Family, Mt. Holly, NJ, April, 1981.

15. Cooke, G., Mullen, J., and Olsson, J. Utilization of Psychiatric and Psychological Assessments by Criminal Court Judges: Description of the Project, Methodology, and Preliminary Results, Presented at the American Psychology-Law Society Convention, 1981, Cambridge, MA.

16. Cooke, G. Psychological Evaluation in Custody Cases, Pennsylvania Bar Association Program on Shared Custody, 1982, Philadelphia, PA.

17. Cooke, G. Evaluation of Allegations of Child Sexual Abuse in Child Custody Cases, American Academy of Psychiatry and the Law Annual Convention, 1986, Philadelphia, PA.

18. Cooke, G. and Nicholas, W.T. Can Forensic Mental Health Professionals Be Friends of the Court? Lenape Valley Foundation Conference, 1987, Valley Forge, PA.

19. Cooke, G. Psychological Evaluations in Child Custody Cases, Pennsylvania Bar Institute Family Law Seminar, 1987, Philadelphia, PA.

20. Cooke, G. Psychological Evaluations in Child Custody Cases, Pennsylvania Bar Institute Family Law Seminar, 1987, Harrisburg, PA.

21. Cooke, G. Psychological Evaluations in Child Custody Cases, Pennsylvania Bar Institute Family Law Seminar, 1987, Pittsburgh, PA.

22. Cooke, G. Cross-Examination of Mental Health Experts in Child Custody Cases, Invited Presentation, Family Law Section, 1988, Annual Philadelphia Bench/Bar Conference, Washington, DC, 10/1/88.

23. Cooke, G. Psychological Evaluation in Child Custody Cases, Pennsylvania Bar Institute Family Law Seminar, 1990, Pittsburgh, PA.

24. Cooke, G. Psychological Evaluation in Child Custody Cases, Pennsylvania Bar Institute Family Law Seminar, 1990, Philadelphia, PA.

25. Cooke, G. Psychological Evaluation in Child Custody Cases, Pennsylvania Bar Institute Family Law Seminar, 1990, Harrisburg, PA.

26. Cooke, G. Family Law Section, Psychologists Forum, Panel Member, Chester County Bar Association, 1991, West Chester, PA.

27. Cooke, G. Psychological Issues for Clients in Custody Cases, Member of a panel presentation to the American Academy of Matrimonial Lawyers, Summer Program, 1992, Hershey, PA.

28. Cooke, G. Anatomy of a Child Custody Case, Panel member for Family Law Practicum, Montgomery County Bar Association, 1992, Norristown, PA.

29. Cooke, G. Family Law Section Psychologists Forum, Panel member, Chester County Bar Association, 1992, West Chester, PA.

30. Sadoff, R., Cooke, G., and Poplar, C. The use of Forensic Experts at Trial (including child sex abuse cases), Association of Trial Lawyers of America, NJ Boardwalk Seminar, 1994, Atlantic City, NJ.

31. Cooke, G. Winning With an Expert Witness, and Discovery in Family Law Litigation, Pennsylvania Bar Institute Family Law Seminar, 1994, Philadelphia and Harrisburg, PA.

32. Cooke, G. Custody Recommendations When There Has Been Domestic Violence Between The Parents, House Republican Policy Committee's Children and Family Task Force Sub-Committee on Protecting Children from Sex Offenders and Family Violence, 1994, Plymouth Meeting, PA.

GUEST LECTURES AND CONSULTS, ETC.

University of Pennsylvania Center for Studies in Social-Legal Psychiatry: 1973-1977, 1982 (Psychological testing in forensic cases), 1992 (Psychological & Neuropsychological Evaluation in forensic cases).

Beaver College: 1973-1975 (Forensic Psychology).

St. Elizabeth's Hospital Federal Forensic Unit, Washington, DC 1974 (Evaluation of competency to stand trial).

Villanova University Law School: 1975, 1984-1986 (Psychological testing in forensic cases).

Philadelphia State Hospital Forensic Unit: 1975, 1982, 1983 (Forensic Evaluations).

Swarthmore College: 1976 (Forensic Psychology).

Temple University Medical School: 1977 (Forensic Evaluations). University of Pennsylvania Law School: 1977-1980 (Psychological Evaluation in forensic cases).

Testimony before the Governor's Task Force on maximum Security Psychiatric Care: 1977.

Bucks County Bar Association: 1977 (Forensic Psychological Evaluation).

Wernersville State Hospital: 1978, 1983, 1991 (Forensic Evaluations) and 1989 (Assessment and prevention of suicides among mental hospital patients).

Allentown State Hospital: 1978, 1981, 1987 (Forensic criminal evaluations and testimony).

Rikers Island, NY Prison Complex: 1979 (as consultant to the National Center for Action on Institutions and Alternatives – Investigation of, frequency, causes and prevention of inmate suicides).

Philadelphia Bar Association: 1979 (Assessing civil competency). Philadelphia Association of Insurance Claims Processors and Adjustors: 1979 (Psychological evaluation in personal injury cases).

Monroe-Carbon-Pike Counties MH/MR: 1980 (Crisis intervention). Northampton County MH/MR: 1980 (Forensic Psychological Evaluations).

Community Services Institute: 1980 (The new insanity legislation), 1983 (Treatment of mentally ill offenders).

Veterans Administration Hospital Out-Patient Clinic, Philadelphia: 1981 (Forensic Evaluation).

Clarke Summit State Hospital: 1981 (Forensic Evaluation). Abington Hospital: 1981 (Forensic evaluation and treatment, privilege).

Harrisburg State Hospital: 1982, 1987, 1988 (Forensic criminal evaluation and testimony).

Philadelphia Psychiatric Center: 1982, 1983 (Forensic evaluation) and 1987 Neuropsychology as a contribution to critical diagnosis).

Pennsylvania Hospital: 1982 (Forensic and neuropsychological evaluation).

Pennsylvania Bar Institute: 1982 (Workshops on the new Shared Custody Act) and 1990 (Psychological evaluation in child custody cases).

Coatesville VA Hospital: 1983 (Forensic Psychology) and 1987 (Forensic Assessment and issues with aggressive patients).

Pennsylvania Association on Probation, Parole and Corrections Annual Meeting: 1983 (Forensic Evaluation).

Philadelphia Society for Clinical Psychologists: 1984 (Forensic Evaluation).

St. Joseph's University: 1984 (Forensic Evaluation).

Jefferson Medical College: 1985 (Forensic Neuropsychological Evaluation).

New Jersey Trial Lawyers Association: 1985 (Psychological evaluation of psychic injuries).

Montgomery County Police Chiefs' Association: 1985 (Psychological screening of applicants).

Norristown State Hospital: 1986 (Mental health professionals and the criminal justice system).

Haverford State Hospital: 1988 (Criminal evaluations for the Court).

Temple University Graduate Department of Psychology: 1989 (Forensic Psychology)

University of Pennsylvania Department of Psychiatry: 1992 (Psychological and Neuropsychological Evaluation in Forensic Cases).

Chester County Prosecutor's Office Training Seminar for County Police Departments: 1992 (Recognition and prevention of suicide in County jails).

Norristown State Hospital: 1993 (Invited Speaker-Forensic Psychiatry and Psychology with Robert L. Sadoff, M.D.).

St. Joseph's University, Graduate Department of Criminal Justice: 1993 (Psychological and Neuropsychological Evaluation in forensic cases).

University of Pennsylvania Law School, Law Clinic: 1993 (Forensic Psychology and Child Custody Evaluation).

The Association of Trial Lawyers of America – NJ, Boardwalk Seminar 1994 (The use of Forensic Experts at Trial), Atlantic City, NJ.

IN THE COURT OF COMMON PLEAS
OF LEHIGH COUNTY, PENNSYLVANIA

COMMONWEALTH OF PENNSYLVANIA, Claimant	:	NO. 682-1988
VS.	:	
RONALD ROMPILLA, Defendant	:	

Oral Deposition of ROBERT SADOFF, M.D., taken pursuant to notice, at the office of Dr. Sadoff, Benjamin Fox Pavilion, Suite 326, Jenkintown, Pennsylvania, on Tuesday, April 23, 1996, beginning at approximately 5:30 p.m., before Geraldine M. Lipp, Registered Professional Reporter, Notary Public, there being present.

ESQUIRE COURT REPORTING

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[2] APPEARANCES:

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[4] THE COURT REPORTER: Will this be the usual stipulations?

MR. WISEMAN: The stipulation is that objections must be made on the record or they are waived.

ROBERT SADOFF, M.D., after having been first duly sworn, was examined and testified as follows:

MR. WISEMAN: We are here for the deposition of Robert Sadoff in regard to post-conviction proceedings in the Ronald Rompilla matter.

DIRECT EXAMINATION

BY MR. WISEMAN:

Q. Will you please state your name.

A. Robert L. Sadoff, S-A-D-O-F-F.

Q. And what's your occupation, Doctor?

A. I am a physician specializing in psychiatry.

Q. And directing your attention to 1988, did you have any involvement in the matter of the Commonwealth against Ronald Rompilla?

A. I did.

Q. And I would like to show you what's been marked in [5] other proceedings in this case as Defendant's Exhibit 2 and ask you to look at that letter.

A. That is a letter that I sent on September 19, 1988 to Maria Dantos who was with the Public Defender's Office in Allentown at that time.

Q. And it indicates that you had some involvement in this case?

A. Yes. It noted that I examined Mr. Rompilla on September 15, four days earlier in 1988, at the Lehigh County Prison. And I had reported my findings to Miss Dantos by telephone and I was awaiting further advice from her.

Q. Did you have occasion to review your files to see if you had any other material in regard to Mr. Rompilla?

Let me clarify. Did you have anything in regard to the trial proceedings, anything emanating from the time of the trial proceedings?

A. I actually don't have my original file on him so what I have is this one sheet of paper that I authored that you sent me and I believe you also sent me (indicating.) So that's all I know about the case.

Q. Okay. Do you have a recollection of the reason that you were requested to evaluate Mr. Rompilla?

A. I do not.

Q. In 1988, would you have had a standard evaluation [6] that you would have done in a capital case?

A. I did, yes.

Q. What would that have consisted of?

A. I would have examined him for competency to stand trial. I would have examined him for criminal responsibilities. And I would have examined him for possibility of mitigating circumstances at the time of the commission of the crime.

Q. And what would that evaluation have consisted of?

A. Consisted of my going to the jail and sitting down with him and talking with him, examining him, doing a mental status examination, which means that I would observe him and I would observe his responses, the way he responded as well as the content of his responses. And if

need be, I would have gotten a psychologist to do psychological testing if I felt they were necessary.

Q. Now, you completed a declaration in this case dated April the 8th, 1996?

A. Yes, I did.

Q. In that declaration, you indicate that you have no recollection right now of having evaluated Mr. Rompilla.

A. That's correct.

Q. You also indicated that you reviewed certain records provided by my office regarding Mr. Rompilla's records.

[7] A. Yes, that's correct.

Q. And just so the record is clear, in paragraph 3 of your declaration, you indicate that those records show on October 1959 a WISC test score of verbal IQ of 61, performance of 75, and a full scale of 64.

Is that true that you reviewed those records?

A. Yes.

Q. And also in April of '57, there was a test score indicating a 75 IQ as well?

A. Yes.

Q. And the records also indicated that Mr. Rompilla was in special education classes at that time of his life?

A. Yes, that's correct.

Q. And in 1961, he scored on a WISC a verbal IQ of 69, a performance of 75 and full scale of 69.

A. Yes, that's correct.

Q. And then finally, the records you reviewed with that in 1974, his Wide Range Achievement Test, put him in a low percentile on that test?

A. Yes.

Q. Now, what do those test scores indicate – withdrawing.

As a psychiatrist, do you routinely administer or ever administer such testing?

[8] A. I do not.

Q. And do you ever interpret the raw data derived from such testing?

A. I do not.

Q. How do you in your practice make use of such testing?

A. If it's conducted by someone that I have requested it be done by, that person will have interpreted the testing and provide me with a report that I may incorporate into my final report.

If the testing is done by someone else who is not available to consult with, I might have my consultant, the psychologist, review the raw data and give me his input or her input on what that means.

Q. Okay. Now, in your declaration, you indicate that some of the testing is in the mentally retarded, or as I think you use the term, developmentally challenged range?

A. That's right.

Q. And is that knowledge you have from your practice?

A. Knowledge I have had from psychologists with whom I have worked over the years, yes.

Q. In looking at these test scores from Mr. Rompilla's childhood, you are able to know the significance clinically of a test score of a full scale [9] IQ of 64?

A. Yes.

Q. And it's in the retarded range?

A. Yes.

Q. Now, in your affidavit or in your declaration, you indicate that the attorneys – and by "attorneys," I assume you are referring to myself. I had spoken to you about these matters.

A. Yes, and I am referring to you (indicating).

Q. And I advised you that Dr. Cooke had testified in a deposition in regard to these proceedings and that he, in fact, worked with you – not worked with you but worked on this case back in 1988.

A. That's my understanding. I have no independent recollection of it. But having worked with Dr. Cooke on many, many cases in the past, I am not surprised.

Q. Okay. And in your declaration, you indicate it's your experience with Dr. Cooke that if he had had access to the scores that are set forth in your declaration, he would have conducted neuropsychological testing. Is that true?

A. Yes. That is true.

Q. Now, as a forensic psychiatrist, if you were presented with these scores and you had not had any type of neuropsychological testing done at that time, would [10] it be your desire to see neuropsychological and psychological testing done to help explain these scores?

A. First as a forensic psychiatrist having had that information and doing my psychiatric examination, I might have examined different questions. I might have probed in the area of reasons why he might have. Is it genetic? Did he ever have an accident or a fall that would have hit his head?

I always ask these questions but I might have probed deeper. Any toxic substances, high fevers that might have caused him to have some brain dysfunction? And I would have recommended a battery of psychological and neuropsychological testing to probe the cause, if we could find it, of these low IQ scores.

And I would also have the psychologist do the testing contemporaneously to compare these scores, to see if there is any increase, decrease or no change.

Q. In your declaration, you note there is an IQ score of 93 in October of '75?

A. Yes.

Q. And that would have been on the BETA testing?

A. Apparently that's correct, yes.

Q. And is that the type of discrepancy that would have caused you to look at possible organicity or other

factors that could explain the differential in the [11] scores?

A. Yes. Usually it goes the other way but when you see someone who has a low IQ as a youngster and it's higher later, you wonder if he was motivated when he was younger or what might have been going on at that time. I would have to explore that discrepancy.

Q. When you say "motivated," would a lack of motivation be caused by emotional interference going back – in a child's background?

A. Yes.

Q. Poverty would be one thing?

A. Again, you are getting into an area where a test may be controlled or regulated or poverty and socio-economic conditions. And I don't know the data on that. That you would have to ask Dr. Cooke.

Q. How about as an emotional interference issue, child abuse?

A. If that's there, if there is anything like that, we have seen it effect [sic] the IQ scores and motivation and school performance.

Q. I guess what I wanted to understand for the record is by "motivation," you are not thinking necessarily that the child was lazy or not a good student?

A. No. I am not thinking that at all. There would be many factors that would interfere with his ability to [12] be motivated or desire to be motivated.

Q. Just to back up a bit in terms of the neuropsychological testing, I would like the record to be clear if we could just briefly go through the types of tests out there to see how they fit into this picture.

If you would explain for the record, what is neuropsychological testing?

A. It's a subset, I guess, of regular psychological testing that probes to see whether there is any brain damage.

Q. Okay. And getting from that more general description to more specifics, what does intelligence testing probe for?

A. You are getting into areas that, again, it's not my expertise. Generally speaking, I would say it probes for intelligence.

Q. Okay. In particular, the Wexler Adult Intelligence Scales, are you familiar with the particular subscales in that test and what they each examine?

A. No.

Q. I think we talked earlier about the BETA. I think you said you don't have a lot of familiarity with the BETA?

[13] A. Not at all. I have heard the name.

Q. How about the Stamford Binet?

A. Again, I have heard of it.

Q. That's something you deal with in terms of –

A. No experience, no expertise.

Q. Now, other areas of neuropsychological function that tests for brain damage or organicity is the Halstead Ritan.

A. I am only familiar with the name and that it's a long detailed test that takes hours to administer and has to be done by a very specialized person that has experience in this field. I have seen parts of it given as part of my training of my students at Penn by neuropsychologists. But beyond that, I mean, I have no expertise with it.

Q. I am going to go through a brief list of names. If there are any that fit into the categories that you do have experience in terms of administering or interpreting, why don't you stop me.

The categories test?

A. No.

Q. Wisconsin card sorting?

A. No.

Q. Denman Neuropsychological Inventory?

A. No.

[14] Q. Iowa Neuropsychological Battery?

A. No.

Q. Finger oscillation or finger tapping?

A. No.

Q. Seashore rhythm?

A. No.

Q. Abstraction testing?

A. No.

Q. Figure design testing?

A. No.

Q. Blot design?

A. No.

Q. Sorting?

A. No.

Q. Short-term/long-term memory comparisons?

A. No.

Q. Internal impairment scales?

A. No.

Q. Placement testing?

A. No.

Q. Trials A and B?

A. No.

Q. Binder-Gestalt?

A. No. I have heard of all of these and I have seen some of these but I have no expertise.

[15] Q. Right. And just – I may have asked about this one. How about the Iowa Memory Testing?

A. You asked and no, I have not.

Q. Okay. And again, the proper person to do this testing is a psychologist with an expertise in neuropsychology?

A. Exactly, yes.

Q. Now, you mentioned earlier when we talked about possible derivations or possible explanations for mentally retarded range IQ testing something about fevers. Could you explain that?

A. Sometimes when children get high fevers when they are a year old or so, the fever as a youngster might effect his brain, might even have, you know, meningitis, or some other type of brain involvement that would leave him scarred or mentally challenged for the rest of his life.

Q. Now, can you give us, say, a sort of ballpark for how high a fever would have to be to be in the realm of one that would cause you concern?

A. Kids get higher fevers than that and probably up to 106 or higher.

Q. How about 105?

A. That's borderline but again, it could. I'm not an expert on it but I've heard that.

[16] MR. McINTYRE: Objection on the record since he is not an expert.

BY MR. WISEMAN:

Q. Let me ask you, Doctor: If you knew at the time you were evaluating Mr. Rompilla and you saw that he had a fever at the age of 2 of 105 accompanied with dehydration related to diarrhea, would that along with this

other information that you did not have, the testing, would that have been another red flag for you to explore possible organicity?

A. Yes, it might have been the organicity. It may have been the cause of some of his low IQ.

Q. Now, again, I realize this may be difficult because you don't have an independent recollection. But from working with Dr. Cooke in other cases, if I were to tell you that Dr. Cooke testified in his deposition that the school record information was a "red flag" to him that would have caused him to do neuropsychological testing, would that be consistent with your experience with Dr. Cooke?

A. Yes, it would.

MR. WISEMAN: I have nothing further. Thank you.

CROSS-EXAMINATION

[17] ---

BY MR. McINTYRE:

Q. Good afternoon, Doctor. We skipped your qualifications but it's true that you are a forensic psychiatrist?

A. Yes.

Q. Board certified?

A. Yes.

Q. In 1988 and now?

A. I was board certified in psychiatry, legal medicine and forensic psychiatry in 1988. The only one I got after

that was added qualifications in forensic psychiatry that came in 1994.

Q. Do you have a CV handy that we could actually append to your deposition?

A. I do.

MR. McINTYRE: Any objection, Mike?

MR. WISEMAN: No.

MR. McINTYRE: We will call it Sadoff-1.

BY MR. McINTYRE:

Q. If I understand correctly – and I know I probably shouldn't even ask you – you have absolutely no independent recollection of your exam of Mr. Rompilla at all?

A. That's correct, I have none.

[18] Q. And you have attempted to look for your file but I take it because of the eight years that have gone by, you don't have that file at all?

A. I don't have it.

Q. So basically, you don't know other than your examination of him at the prison which you see from your letter to the public defender, what you may have relied upon?

A. I don't know what I relied upon, no.

Q. You don't know if Dr. Cooke sent you anything, I take it?

A. I don't remember. He may have. I don't remember.

Q. Do you even know that you worked with Dr. Cooke on this case?

A. I have no independent recollection of that but it's likely that I did.

Q. Back in 1988, you were working in tandem with the psychologist Dr. Cooke?

A. I still do on occasion. Sometimes we are on the opposite sides of cases but very often we are on the same side. And if I have my choice, I actually choose to have Dr. Cooke as my associate in cases. But I trust his judgment and worked with him for years.

Q. Since we don't know whether you did work with him or not, I will ask you questions about what the standard [19] procedure would be.

Was there a standard procedure in cases that you and Dr. Cooke worked on together?

A. It wasn't standard but it was something we did frequently together. We would see the defendant independently and then before I prepared a report, he would send me a copy of his. And I would often incorporate the findings that he has in mine since he would be like a consultant to me in the sense that I would prepare a forensic psychiatric report. And part of my final opinion would include what was found in the testing.

Q. And are you familiar with the standard tests that Dr. Cooke did back in 1988?

A. I am familiar with some of those that he did then and he probably still does now but I don't know which ones he did in this case.

Q. I think I have those. I would just get your confirmation that these were the standard tests that Dr. Cooke did that you are familiar with.

A. MMPI.

A. Yes.

Q. Rorschach?

A. Yes.

Q. The Wexler IQ test?

[20] A. Yes.

Q. And I believe the Incomplete Sentence Test?

A. Yes.

Q. Is it fair to say that those were four standard tests that Dr. Gerald Cooke did back in 1988?

A. I believe he did them fairly regularly, yes.

Q. And you would get the results of those tests?

A. I would not get the results. I would get his interpretation of those or whatever else he may have done as a battery of tests. And he also did his own psychological interview and examination which he would include in his report.

Q. And then you would have those test results and then go see the defendant yourself?

A. Usually I would see the person first and I would say, "I think we need a battery of tests." And I would ask for those and then I would get his report before I prepared

my own. Or if I did my own report for whatever time requirements there may have been for discovery, I might then do an addendum after I get his.

Q. All right. Now, the tests we spoke of, that Wexler, that is an IQ test; correct?

A. Yes, it is.

Q. Was it standard for Dr. Cooke to administer that particular IQ test back in 1988 in the cases you worked [21] on with him?

A. I can't remember that in terms of 1988 or if that was the one he used more frequently than any but I would say it's a familiar test that I have heard him talk about and that I have seen in reports that he has used.

So generally speaking, I would say yes.

Q. All right. And I take it it was standard procedure for you to rely on his report of the results of that IQ test?

A. Yes. I would have no way of disputing that.

Q. Dr. Sadoff, can you think of any one case from any time that you have worked with Dr. Cooke in which grade school records were requested in addition to Dr. Cooke's conduction of his own IQ test?

A. I can think of a lot of cases that I know he wanted them and because he asked for them, we both got them. He would think of them more frequently than I would because that's the nature of his work. Usually, if there's a juvenile involved, he would want all the school records. I know that. And I would want them, too, especially if we are talking about his ability to be treated in the juvenile system.

Q. I think Mr. Rompilla was 40 years old in 1988.

A. Four years old?

Q. Forty. Do you know of any cases in which [22] 30-year-old grade school records would be requested by either you or Dr. Cooke?

A. I think Dr. Cooke would request them if he found that there were discrepancies in IQ that he would want to look at and see what the performance was in school, was it compatible and consistent with the IQ scores that are reported or is there a discrepancy. I think he would have asked for that.

Q. What would have triggered or made him request these grade school IQ test results?

A. I think if he found that he got a 93 on one and that he sees reports of 64, 61, 70, that's too much of a difference. He might ask how far back do those go, what was he like in school, are there school records that might know what his IQ might have been, his grades and the comments made by teachers about performance and his behavior and so on.

Q. So what you are saying is if he did his tests, his own IQ test, and then had some other test that was a discrepancy between the two, then he would order the grade school records?

A. I think so.

Q. Can you think of a case in which he had no test at all, he just did his tests and for some reason, he asked for grade school tests?

[23] A. He might – for example, he had no other data except what the defendant told him. Suppose the defendant told him that he had graduated from college. One would expect an IQ of 120 or so. Suppose he tests out at 73. No 73 IQ is going to graduate from college. He might ask for school records to see if he really graduated from college.

If he gets those records and it shows he did very well, he might want to go back and see if there were instances of his doing poorly in his earlier years, to see if it goes up and down, is it a straight line, does it go across like that. I think he might then, but only then if he has a real discrepancy in what the person told him and what he tests out to be.

Q. All right. So basically what you are saying is, unless there is some type of discrepancy in another test or between what the defendant told him and the test results, he wouldn't have asked for those?

A. He might not have in a 40-year-old person to go back to grade school records unless there was a reason to do so.

Q. You didn't ask for grade school tests as a standard part of your evaluation of a 40-year-old defendant, did you?

A. No, I did not.

[24] Q. Now, looking at your letter to attorney Dantos dated September 19, 1988 – which for the record, I guess, is Defendant Exhibit 2.

MR. WISEMAN: That's right.

BY MR. McINTYRE:

Q. Is it fair for us to infer from that that you found nothing favorable to Mr. Rompilla in your examination?

A. I think that's very fair.

Q. And I take it since one of the things you were looking for was mitigation since this was a capital case, it's fair for us to infer you found no mitigating evidence?

A. On my examination, that would be fair.

Q. You were requested to examine Mr. Rompilla?

A. Yes.

Q. And that you did?

A. Yes.

Q. Has the state of the art of forensic psychiatry changed from 1988 to the present?

A. That's a good question. I can only say that my examinations tend to be more thorough as I get older and have the wisdom of cross-examination about what I didn't I do earlier. And so having learned that, I usually try to incorporate that into my next examination.

[25] So the state of the art for me is – I think there have been a number of changes in forensic psychiatry that were caused by changes in law that we have to adhere to. But as far as if I can read between the lines of your question and what I think you are asking is do we do anything differently today than we did back in 1988 –

Q. That's correct.

A. If anything, I probably spend more time with people than I did before and probably ask a lot more questions. And again, those questions are ones that I was embarrassed that I didn't ask when I was asked on cross-examination if I did that. I don't do that in all cases but having learned that, I do try to teach it to my students as well. And I expect if it's changed in any way, it's changed we do spend more time.

Q. How about in your use of a psychologist and the testing that's done? Is there any change in that from what was done in 1988?

A. I don't think I would have changed in that because I have always used – I don't like the word "used" but I have always consulted with psychologists. And Dr. Cooke goes way back from 1970 even, maybe '75. So it's many, many years. And I have found that to be a very important part of my total forensic assessment, [26] especially in criminal cases. And I very often request the psychological battery.

Q. But are the tests that you are requesting the same now that they were in 1988?

A. That I can't tell you because I don't select them. I just say, "Do your usual standard battery." I think Dr. Cooke would be in a better position to answer that question.

Q. You can't tell from the results that you get from your psychologists today whether or not they are doing different tests?

A. If I am, I really can't recognize it.

Q. In your affidavit or your declaration, I guess is more correct, you indicate that you don't have any direct experience with the WRIT?

A. That's correct.

Q. You also note something about the IQ test that was conducted in October of 1975.

A. Yes.

Q. Did you know that was a BETA IQ test?

A. I have no independent knowledge of it now. If that's in the record that they sent me, it might have been. But again, I don't purport to have any expertise in that.

Q. Do you know whether or not there is any [27] discrepancy in a 93 IQ score in a BETA IQ test as compared with the other test results in different IQ tests?

A. I couldn't tell you that.

Q. All right. So there may not even be a discrepancy?

A. There may not. That's really up to the psychologists.

MR. McINTYRE: Okay. I have nothing further.

MR. WISEMAN: Just a little bit of follow-up just a couple of moments.

REDIRECT EXAMINATION

BY MR. WISEMAN:

Q. Is brain damage relevant to mitigation in your view?

A. Yes.

Q. And is retardation?

A. Yes.

Q. And is poor performance in school?

A. If the poor performance in school is continued as poor performance later in life, it would be a factor. If he overcomes the poor performance in school and has [28] good performance in work and life and other things, it may not be as important a mitigating factor.

Q. Now, brain damage and retardation and poor performance, to the extent you have just described as mitigation, were they mitigators, in your view, in 1988?

A. Yes.

Q. And before?

A. Yes.

Q. Neuropsychological testing was around in 1988?

A. Yes.

Q. Intelligence testing?

A. Yes.

Q. Memory testing?

A. Yes.

Q. And brain damage?

A. Yes.

Q. That's something the field knew about back in 1988, and well before?

A. Yes.

Q. If the records that we have been discussing today and in your declaration been provided to you and Dr. Cooke, would you have considered them in your mitigation evaluation?

A. If they were sent to me, I would have, yes.

Q. By the way, when you indicated that you don't – [29] actually, Mr. McIntyre in his questioning said eight years later, your file appears not to be in existence.

Do you have a standard practice for when you destroy your files?

A. I am overflowing now and what I do is I have a storage bin downstairs that has old records but they are not well filed. I keep them for whatever reason but I have not had a chance to go down there and look for them. It may be down there. I haven't looked and I don't know.

Q. Okay. I just want to show you a letter that's been marked previously in this case as Defendant's 3. It would be a letter from Dr. Cooke dated June of '88 also to Maria Dantos. It appears from that letter that Dr. Cooke, as indicated in your letter as well, did not write a report about this case.

A. Right.

Q. And that's approximately four months before your evaluation.

A. Yes.

Q. And would it be fair to say that if Dr. Cooke did not write a report, that you would not have had a report to review, obviously?

A. I would not have had a report.

Q. So all the questions Mr. McIntyre was asking you [30] in regard to your relying on Dr. Cooke in this case, in fact, it is quite likely you didn't rely on him at all?

MR. McINTYRE: Object to the form.

THE WITNESS: I don't recall whether we talked on the telephone or not. Very often, he gives me input but I don't recall in this case whether he did.

BY MR. WISEMAN:

Q. By the way, your declaration, I take it, is a true reflection of the views that you expressed on April 8, 1996.

A. Yes.

Q. For purposes of the record, I would mark it as Sadoff-2. We can figure out later how it fits into the numbering scheme.

What's the significance, Dr. Sadoff, of collateral information in the forensic setting with a particular focus on a capital case?

A. Good question. I like to use collateral information in any case I have, whether it's capital or not. I think in

forensic work it isn't the same as a person coming to me because he's hurting, he's in emotional pain and he wants relief of that pain.

He comes to me because he's involved in some difficulty, civil or criminal. And the veracity, validity, credibility, whatever word you use, is not of [31] the same caliber as if he were coming for treatment. So it's very important for me to have collateral information that would either substantiate or negate what he tells me.

Q. In laymen's terms, is what you are saying is that defendants in a forensic setting are not always the most reliable sources for the information you need as a provider to make an informed judgment as to their forensic condition?

A. That's a fair way of putting it.

Q. People sometimes minimize mental illness?

A. Or maximize.

Q. Yes.

A. Either way.

Q. Sure. And sometimes people minimize poor backgrounds like child abuse, like – let's take child abuse. Have you had experience with people who minimize?

A. I have people who haven't told me about it when it was there. I have people who have told me that it happened to them that cannot be corroborated. So I think it can be exaggerated or minimized, either way.

Q. And particularly, if you are dealing with a forensic patient who has a low IQ, has cognitive problems and

possibly brain damage, their reliability as [32] a historian, their background, is more suspect than if you are dealing with a genius, for example.

A. I would think there are so many factors you would request. I would think because of low IQ, they would not give as much information. It may not be as reliable. When you get to the genius IQ – and I have seen a number of defendants in this category – they may give you information that they have concocted also that is not reliable, but in the other direction because they are so bright and so able. So again, it can work either way. And one needs to have some collateral or corroborating information to support what the patient says.

Q. Now, let me ask you: If you have – and this is hypothetical because we don't know exactly what Dr. Cooke administered in '88. Assuming he administered an IQ test that showed normal range IQ, not particularly smart, not particularly low intelligence, and had no other IQ testing to rely upon, I guess what I am not following in your answers to some of Mr. McIntyre's questions is what is the potential for discrepancy if you are only looking at one test without collateral information?

A. You don't know. You don't know. The only potential is – suppose the history is that he told [33] Dr. Cooke that he graduated from college and he has a fairly low IQ. That's a discrepancy of another test. Or he told Dr. Cooke that he was in special education classes and didn't get through the ninth grade and he has a normal IQ. That would also be a discrepancy.

Q. Right. Let's assume, then, for this hypothetical that the person reports to Dr. Cooke that he stopped going to high school in the ninth or tenth grade just because he

wanted to work and gave no – he neither graduated from college nor told Dr. Cooke he was in special ed but just basically said, I am a regular Joe and I dropped out of school to work.

Where would be the discrepancy – well, withdrawing. Wouldn't it have been proper or appropriate to try to obtain collateral sources to see if there is, in fact, a discrepancy in the present day testing?

A. Not necessarily. If he gives you an average background and he has an average IQ and everything looks pretty normal and you have no reason to suspect a discrepancy, you might not ask for anything more, especially if you have particular questions that you are asked to address. You have a limited budget, a limited time and you have to try to come to some kind of an opinion within a reasonable time frame and don't think [34] that spending a lot more money or time is going to give you any more information than you already have.

Q. Assume that obtaining the records that we have provided to you regarding Mr. Rompilla's schooling is not an economic issue for the lawyers at the time, wouldn't have cost him anything to get it. Is that the kind of information that you would find useful as collateral information in your forensic evaluation?

A. Yes.

Q. Are there in your experience capital cases where lawyers do provide you with collateral information?

A. Oh, sure.

Q. Things like school records?

A. Yes.

Q. Even without you asking?

A. Yes.

Q. As a matter of routine?

MR. McINTYRE: Note my objection.

MR. WISEMAN: What's the basis?

MR. McINTYRE: You are asking him for opinions which would go to attorney malpractice or incompetence. He is not qualified to do that.

MR. WISEMAN: I thought it was a fair response to some of the questions you were asking him.

BY MR. WISEMAN:

[35] Q. And just to follow up on that, that would have been true certainly as far back as 1988, if not earlier?

MR. McINTYRE: Same objection.

THE WITNESS: My recollection is – and again, I haven't but those that I have had in different states, some of them, of course, were like this one that's on appeal and I got all the records. When it is a fresh case that becomes a capital case and I have to evaluate as much as I can and we are pretty sure it's going to go to the second phase, let's say, the sentencing phase of the case, then we do try to get as much information as we can.

MR. WISEMAN: Okay. Nothing further.

MR. McINTYRE: I have a couple questions.

RECROSS-EXAMINATION

BY MR. McINTYRE:

Q. Dr. Sadoff, it wasn't standard for attorneys to provide you with grade school tests of 40-year-old defendants facing capital cases back in 1988, was it?

A. I don't know what's standard for lawyers and I didn't mean to get into the area of attorney malpractice. It really is not my intent.

What was standard was when I was involved in a [36] case and we were focusing on mitigating circumstances that could help in terms of death penalty at the sentencing phase, it was my practice to get as much information as I could if I thought it could be helpful.

Now, there are some cases where I didn't think I could be helpful even if we got other information because it was clear to me there was nothing I could hook onto that would help me in this particular case. And that's probably why I wrote such a letter. But I don't know what was standard for lawyers. What I know was standard for me is if I felt I could help, I would try to get as much information as I could. If that included the grade school records, fine. The psychologists often would get all of those and I would have them because he or she would. I didn't ask for them.

Q. Let me ask you one other question. It may take a couple to develop it.

You are aware that the mitigating circumstances in Pennsylvania back in 1988 and present were the following:

That the defendant was under the influence of extreme mental or emotional disturbance?

A. Yes.

Q. Or two, the capacity as a defendant to appreciate the criminality of his conduct or to conform his conduct [37] to the requirements of law was substantially impaired. You can't –

MR. WISEMAN: I would just object. Are those all of the mitigating factors or are you mentioning mental health factors?

MR. McINTYRE: Those are the mitigating factors –

MR. WISEMAN: You said those are the only mitigating factors.

BY MR. McINTYRE:

Q. We will stick with these.

A. I am familiar with those.

Q. You can't say to any degree of psychiatric certainty that those grade school IQ test scores that you now have seen from Mr. Rompilla evidence either of those, can you, standing alone?

A. Standing alone, they don't. What I look for is are they a building block in terms of reflecting that he may have had brain damage that we didn't find. And that's why they would have been important, but not by themselves.

Q. Can you think of any other mitigating circumstances that those grade school IQ tests standing alone

would be evidence of that you could testify to a reasonable degree of psychiatric certainty?

[38] A. No, only if they reflected that he had brain damage. I think just the grade school records alone are not going to help us by themselves standing alone.

MR. McINTYRE: All right. I have no further questions.

FURTHER REDIRECT EXAMINATION

BY MR. WISEMAN:

Q. Just a little follow-up on that last question. Are you familiar with the so-called catch-all mitigator in Pennsylvania, any other factor about the defendant's background?

A. Yes.

Q. In your experience, would scores indicating mental retardation during childhood, would that be something that would fall in the catch-all by itself?

A. See, in and of itself it doesn't. If it affected his state of mind at the time of the commission of the fact for which he was charged and they could develop that it was a factor in that from back in childhood, then it is important. But if, for example, you have those and they are not a factor in the criminal behavior, then I would say no.

Q. Would it be fair to say, then, Doctor, just so I [39] understand from the record, that your understanding of mitigation is that it is only mitigating if it relates to the

defendant's state of mind at the time of the commission of the offense?

A. It relates to that and the kind of person he is, is he treatable, is this something – because the mitigating factors, as I read them, reflect state of mind at a particular time. I have not in my experience used irrelevant material that had nothing to do with the crime itself as a mitigating factor. It had to be something that would have impacted on his state of mind at the time.

Q. And one final question: Do you have any recollection that the lawyers in the Rompilla case gave you any different view of what they were looking for in terms of mental health mitigation?

A. I have no recollection.

MR. WISEMAN: Nothing further.

(Whereupon, Exhibits Sadoff-1 and Sadoff-2 were marked for purposes of identification.)

(Whereupon, the deposition concluded at or about 6:30 p.m.)

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[40] CERTIFICATE

I, GERALDINE M. LIPP, R.P.R., do hereby certify that ROBERT SADOFF, M.D., was by me first duly sworn to testify to the whole truth and that the above deposition was recorded stenographically by me and was transcribed

by means of computer-aided transcription under my personal direction and that the said deposition constitutes a true record of the testimony given by said witness.

I further certify that I am not a relative or employee or attorney of any of the parties, or a relative or employee of such attorney, or financially interested directly or indirectly in this action.

/s/ Geraldine M. Lipp
GERALDINE M. LIPP
REGISTERED PROFESSIONAL
REPORTER

EXHIBIT 1

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CURRICULUM VITA

Birth Date:	Minneapolis, Minnesota February 8, 1936
Education:	Bachelor of Arts (BA), University of Minnesota, 1956
	Bachelor of Science (BS), University of Minnesota, 1957.
	Doctor of Medicine (MD), University of Minnesota School of Medicine, 1959.

	Master of Science (MS) in Psychiatry, University of California at Los Angeles, 1963.
	Thirty-three credits in Law, Temple University School of Law, 1963-66.
Internship:	Wadsworth Veterans Hospital, Los Angeles, CA, General Rotating Internship, 1959-60.
Residency in Psychiatry:	U.C.L.A. Neuropsychiatric Institute, Los Angeles, CA, 1960-63.
Military:	Captain, U.S. Medical Corps, Walson Army Hospital, Ft. Dix, NJ, 1963-65.
Fellowship in Forensic Psychiatry:	Temple University Schools of Law and Medicine, 1965-66.
Board Certification:	Certified in Psychiatry by the American Board of Psychiatry and Neurology, May 1966.
	Certified in Forensic Psychiatry by the American Board of Forensic Psychiatry, February 1979.
	Certified in Legal Medicine by the American Board of Law in Medicine, December 1981.
	Certified by the American Board of Psychiatry and Neurology – Added qualifications in Forensic Psychiatry, October 1994.
	Member, Board of Directors – American Board of Forensic Psychiatry, 1977-83, President, 1982-83.

Member, Board of Directors – American Board of Law in Medicine, 1980-1985

Licensure:

Minnesota	Pennsylvania
California	New Jersey
New York	

CURRENT ACADEMIC APPOINTMENTS

University of Pennsylvania
- Clinical Professor Psychiatry
- Director, Center for Studies in Social-Legal Psychiatry
- Director, Forensic Psychiatry Clinic

EDITORIAL APPOINTMENTS:

[a] Associate Editor, *Bulletin of the American Academy of Psychiatry and the Law.* 1973-1983.

[b] Editorial Board, *Journal of Psychiatric Education,* 1980-88.

[c] Editorial Consultant: *Journal of Law and Psychiatry.*

[d] Board of Editors, *International Journal of Medicine & Law.*

[e] Editorial Board, *American Journal of Forensic Medicine & Pathology.*

[f] Editorial Board, *Forensic Science International*, 1985-92

[g] Editorial Board, *Contemporary Psychiatry*, 1987-1991

[h] Board of Editors of the *Journal of Forensic Psychiatry*, 1989-

PROFESSIONAL AFFILIATIONS:

American Medical Association
Pennsylvania Medical Society
Montgomery County (PA) Medical Society
American Psychiatric Association (Fellow, 1971-)

[a] Member, Manfred Guttmacher Award Board, 1971-74; Chairperson, 1979-84.

[b] Member, American Psychiatric Association Task Force on the Right to Treatment, 1974-76.

[c] Member, Committee of Psychiatry and Law, 1976-79

[d] Member, Committee of Abuse/Misuse of Psychiatry in the United States, 1980-84.

[e] Member, Committee on Psychiatric Treatment in Correctional Facilities, 1983-86.

[f] Member, Task Force on the Use and Misuse of Psychiatric Diagnoses in the Courts, 1988-.

[g] Member, Isaac Ray Award Board, 1988-

Pennsylvania Psychiatric Society (Fellow, 1969)

[a] Member, Committee of Professions and Associations, 1972.

Philadelphia Psychiatric Society
American Academy of Psychiatry and the Law, President, 1971-73

[a] Chairman, Committee on International Relations, 1984-92.

American College of Legal Medicine, (Fellow, 1970-).

[a] Member, Committee on Legislation, 1972;

[b] Member, Education Committee, 1977-80;

[c] Member, Nomination Committee, 1979-81.

American Academy of Forensic Sciences (Fellow, 1972)

[a] Chairman, Section of Psychiatry, 1977-78.

American College of Psychiatrists, (Fellow, 1983-).
Member, Laughlin Committee, 1990-1994.
Fellow, Philadelphia College of Physicians, 1980-.

HOSPITAL APPOINTMENTS:

[a] Current:

[1] Hospital of the University of Pennsylvania, 1973-;

[2] The Institute of the Pennsylvania Hospital, 1983-;

[3] Philadelphia Psychiatric Center, 1980-;

[4] Albert Einstein Medical Center, 1971-;

[5] Consultant in Forensic Psychiatry, Harrisburg State Hospital, 1986-.

[b] Past Appointments

[1] Norristown State Hospital; Consultant in Forensic Psychiatry, 1965-74;

[2] Temple University Hospital, 1965-72;

[3] Philadelphia General Hospital, 1965-72;

[4] Abington Memorial Hospital, 1967-69;

[5] Trenton Psychiatric Hospital, Consultant in Forensic Psychiatry, 1979-83.

[6] Friends Hospital, 1975-1986.

PREVIOUS ACADEMIC APPOINTMENTS:

[A] Temple University School of Medicine, Department of Psychiatry:

Clinical Assistant Professor of Psychiatry, 1970-72; Instructor in Psychiatry, 1965-69.

Temple University School of Law:

Temple University Schools of Law & Medicine Lecturer in Law, 1966-72.

Unit in Law and Psychiatry:

Research Associate, 1965-68; Training Supervisor in Forensic Psychiatry, 1968-72;

Director, Forensic Psychiatry Clinic, 1965-66;

Clinical Director, State Maximum Security, Forensic Diagnostic Hospital, Holmesburg Prison, 1966-68.

[B] Villanova University School of Law:

Lecturer in Law, 1972-85.

OTHER APPOINTMENTS AND AWARDS

The Philippe Pinel Award, given by the International Academy of Law and Mental Health, June, 1995, Tromso, Norway.

The Earl Bond Award for Outstanding Teaching in Psychiatry, University of Pennsylvania, 1979.

Recipient, Nathaniel Winkelman Award, November 16, 1988.

Recipient (with Robert I. Simon, M.D.), Manfred Guttmacher Award for Best Publication in Forensic Psychiatry, 1992.

Joseph J. Peters Institute Polaris Award Recipient, 1995.

Distinguished Professor Award, Florida Hospital Center for Psychiatry, 1994.

The Best Doctors in America, 1992-1993-1994-1995.

Chairman, Guttmacher Award Board, American Psychiatric Association, 1979-84.

American Bar Association Commission on the Mentally Disabled, 1980-83.

Consultant, National Institute of Justice, 1980-83.

Who's Who in the World, 1991

Who's Who in America 1989

Consultant, National Institute of Mental Health, 1978-83.

Mentor, International Society of Philosophical Enquiry, 1987-.

Visiting Clinical Professor of Psychiatric Medicine, East Carolina University School of Medicine, Greenville, NC, 1984-.

Visiting Professor of Psychiatry, Penn State University Hershey Medical Center, 1974-.

Visiting Professor of Psychiatry, University of South Florida, Tampa, Florida, 1980-82.

Consultant, Veterans Administration Hospital, Philadelphia, PA, 1975-.

Faculty, Continuing Medical Education, Institute of the Pennsylvania Hospital, 1975-.

Pennsylvania Governor's Task Force for the Mentally Ill Offender, 1977-78.

Consultant, VROOM building, Trenton Psychiatric Hospital, Trenton, NJ, 1979-83.

Member, Board of Directors, Center for Rape Concern, Joseph J. Peters Institute, Philadelphia, PA, 1978-.

Director, National Commission on Confidentiality of Health Records, 1977-79. (for AAPL)

Associate Psychiatrist, State Correctional Institution at Philadelphia, 1965-68.

Member, Board of Directors, Montgomery County Mental Health/Mental Retardation Association, 1972-1974.

Participant, Crime Commission of Philadelphia, Research Project on Coordination of Psychotherapy for Criminals.

Faculty Member, Third Judicial Sentencing Institute for Pennsylvania Judges, Allentown, PA, December, 1966.

Group Psychotherapist, Sex Offender Research Project, Philadelphia General Hospital, Philadelphia, PA, 1967-72.

Member, Monitoring Committee, Greystone Park Psychiatric Hospital, (Doe v. Klein), Morristown, NJ, 1978.

Consultant in Forensic Psychiatry, Albert V. Cutter Psychiatric Boards Review Course, Buffalo, NY, 1967-77.

Consultant to Broadside, a community foster home for adolescent boys, Philadelphia, PA, 1970-73.

Member, Board of Directors and Chairman of Committee on Research and Development of TODAY, Inc. (Treatment of Drugs Among Youth) a residential drug rehabilitation center, Bucks County, PA, 1970-74.

Member, Committee to Prepare Standards for Mental Health Treatment in Jails and Prisons, 'American Medical Association, 1979.

Visiting Professor of Psychiatry, St. Vincent's Hospital, New York, NY, 1980-.

Consultant in Psychiatry, Philadelphia Psychiatric Center, 1980-.

American Bar Association Task Force IV Special Dispositional Statutes and Mentally Disabled Convicts of the Standing Committee on Association Standards for Criminal Justice, 1980-.

National Institute of Mental Health Project Utilization of Psychiatric and Psychological Assessments by Criminal Court Judges, Project Advisory Committee Member, 1980-82.

Jewish Academy of Arts and Sciences, Vice Chairman, 1985-.

Member, National Board of Directors, American Red Magen David for Israel, 1977-.

National President, American Red Magen David for Israel, 1987-.

Board of Directors, International Academy of Law and Mental Health, 1989-.

Special Lectures:

The First Annual Leon Yochelson Memorial Lecture, Washington, DC, 1983.

The Fourth Annual Lecturer, Kenneth Appel Memorial Lecture, College of Physicians of Philadelphia, September, 1986.

The Sixth Annual Winkelman Lecture, Philadelphia Psychiatric Center, November 16, 1988.

The Baldwin Keyes Honorary Lecture, Thomas Jefferson University, November 30, 1988.

The Fifth Annual Robert S. Garber Lecture on Medical Ethics, Carrier Clinic, Belle Mead, New Jersey, July 13, 1989.

William Schumacher Annual Lecturer (with John R. Petrila, Esquire) Portland, Maine, October 9, 1992.

National Lectures

Most states in the United States, including medical schools, universities, law schools, private and governmental hospitals and state psychiatric associations.

International Lectures

Lectures in Canada, England, Ireland, Scotland, West Germany, Greece, Israel, Japan, China, Australia, Italy, Sweden.

BIBLIOGRAPHY: Journal Articles:

1. Reducing Sugars in the Blood of Newborn Infants, Sadoff, R.L., & Ulstrom, R. A., *Minn. Med. Bulletin*, 30:387, April 1959.
2. The Physician as an Expert Witness, Sadoff, R.L., *Physician's Panorama*, 2:17-18, September 1964.
3. Group Psychotherapy for Stutterers, Sadoff, R.L., Collins, Keeler, W.J., *Amer. J. Psychiat.*, 122: 1344, 1966.
4. Experiences with a University-Affiliated Psychiatric Service in a Correctional Institution, Heller, M.S., Sadoff, R.L., *Corr. Psychiatr, & J. of Soc. Therapy*, 12:240, 1966.

5. Psychiatric View of the Sexual Psychopath Statutes, Sadoff, R. L., *Corr. Psychist. & J. of Soc. Therapy*, 10:242, 1965.

6. Psychiatry Pleads Guilty, Sadoff, R.L., *Amer. Bar Ass'n. J.*, 51:48, 1965.

7. "Military Law", Section X, Part A, and "The Dangerous Offender" Section VI, Part B., Sadoff, R.L. in *Insanity Procedures Under Federal Law*, edited by Heller, M.S. & Polsky, S., Temple Univ. Unit in Law & Psychiatry Research Series, pp. 121-136 and 324-350.

8. The Forensic Psychiatry Clinic: Model for a New Approach, Sadoff, R.L., Heller, M. .S., Polsky, S., *Amer. J. Psychiat.*, 123:11, May, 1967, pp. 1402-1407.

9. Crying and Weeping in Emotional and Psychosomatic Disorders, Sadoff, R.L., *Psychosomatics*, 6:229, 1966.

10. On the Nature of Crying and Weeping, Sadoff, R.L., *Psychiatric Qu.*, 40:490, 1966.

11. Psychiatric View of Insanity in Divorce & Annulment, Sadoff, R.L., Pennsylvania Bar Ass'n. Q., 37:1, 1966.

12. Psychiatric Involvement in the Search for Truth, Sadoff, R.L., *American Bar Ass'n. J.*, 52:251, 1966.

13. Combining Medical & Psychiatric Management of a Patient With Recurrent Myocardial Infarctions & Significant Family History, Sadoff, R.L., & London, A.M., Psychosomatics, 7:218, 1966.

14. Opportunities for Research in Pennsylvania's Newly Planned Correctional Institution, Heller, M.S., & Sadoff, R.L., *The Prison Journal*, 46:32, 1966.

15. Developing Clinical Facilities in Forensic Psychiatry, Heller, M.S., Sadoff, R.L., Polsky, S., *Amer. J. Psychiat.*, 124:1562, 1968.

16. Aphasia Due to a Right Hemisphere Tumor in a Right-Handed Man, Sadoff, R.L., Holmes, J.E., *Neurology*, 16:392, 1967.

17. Passive Dependency in Stutterers, Sadoff, R.L., Collins, D.J., *Amer. J. Psychiat.*, 124:1126, 1967.

18. Sexually Deviated Offenders, Sadoff, R.L., *Temple Law Q.*, 40:305, Spring, 1967.

19. Tortious Liability of the Insane: A Psychiatric Evaluation, Sadoff, R.L., Penna. *Bar Ass'n. Q.*, 39:73, 1967.

20. Mental Illness and the Criminal Process: Role of the Psychiatrist, Sadoff, R.L., *Amer. Bar Ass'n. J.*, 54:566, 1968.

21. Mental Illness and Civil Law: Expanding Role of Psychiatric Consultation, Sadoff, R.L., *New York Law J.*, Aug. 14-15, 1968.

22. Who Should Have a Gun: Some Preliminary Psychiatric Thoughts, Rotenberg, L.A., Sadoff, R.L., *Amer. J. Psychiat.*, 125:841, Dec. 1968.

23. On Changing Group Therapists, Sadoff, R.L., Resnik, H.L.P., Peters, *Psychiatric Q. Supplement*, 42:156, 1968.

24. On Guns: History, Dynamics and Control, Rotenberg, L.A., Sadoff, R.L., *Corrective Psychiat. & J. of Soc. Therapy*, 16:82, 1970.

25. A Unique Forensic Diagnostic Hospital, Jablon, N., Sadoff, R.L., Heller, M.S., *Amer. J. Psychiat.*, 126:1663, 1970.

26. Myths Regarding the Sex Criminal, Sadoff, R.L., *Medical Aspects of Human Sexuality*, 3:64, July, 1969.

27. A Psychotic Reaction to Magnicide, Sadoff, R.L., Boxer, A.D., *Corrective Psychiat. & J. of Soc. Therapy*, 15:86, Fall, 1969.

28. Court Martial in Vietnam, Danto, B., Sadoff, R.L., *Corrective Psychiat. & J. of Soc. Therapy*, 15:65, Fall, 1969.

29. Establishing Psychiatric Services for Sex Offenders in the Community, Peters, J.S., Sadoff, R.L., *Federal Probation Q.*, 35:33, Fall, 1971.

30. Clinical Observations of Pedophiles, Sadoff, R.L., Peters, J.J., *Med. Aspects of Human Sexuality*, 4:20, Nov. 1970.

31. Civil Law and Psychiatry: Newer Dimensions, Sadoff, R.L., Amer. *Bar Ass'n. J.*, 56:165, Feb., 1970.

32. The Expanding Role of Psychiatric Consultation in Civil-Legal Procedures, Sadoff, R.L., in *Legal Medicine Annual*, ed., Cyril H. Wecht, M.D., Ch. 19, p. 405, 1970. Appleton, Century, Crofts, N.Y.

33. Clinical Measure of Enforced Group Psychotherapy, Sadoff, R.L., Roether, H., Peters, J.J., *Amer. J. Psychiatr.*, 128:224, 1971.

34. The Role of the Psychiatrist as Consultant in Therapeutic Abortion, Sadoff, R.L., Owens, R., *Penna. Medicine*, 74:63, May, 1971.

35. Clinical Aspects of Parricide, Sadoff, R.L., *Psychiatric Q.*, 45:65, 1971.

36. Criminal Behavior Masking Mental Illness, Sadoff, R.L., *Corrective Psychiat. & J. of Soc. Therapy*, 17:41, 1971.

37. Confidentiality in Enforced Group Psychotherapy, Sadoff, R.L., Roether, H.A., Peters, J.J., Presented at American Psychiatric Ass'n. Meetings, Dallas, Texas, 1971.

38. The Psychiatrist as Consultant in Civil and Criminal Law, *Penna. Bar Ass'n. Q.*, Vol. 43, p. 176, June, 1972.

39. LSD and the Insanity Plea: A Note of Caution, Danto, B., Sadoff, R.L., *Newsletter* of the American Academy of Psychiatry & the Law, Vol. II, No. 2, January, 1971.

40. The Doctor as an Expert Witness, *Medical Insight*, Oct., 1972.

41. Frottage: A Multi-faceted Phenomena, *Med. Aspects of Human Sexuality*, Vol. 5, June 5, 1971.

42. The Group That Failed, *Psychiatric Q.*, Vol. 47, 1973, pp. 110-116.

43. The Importance of Informed Consent, *J. of Legal Med.*, May/June, 1977, pp. 25-27.

44. Traumatic Psychosis, in *Personal Injury Annual*, ed. by L. R. Frumer, M.K. Mintzer, Matthew Bender, Publ., NY, 1973, p. 207.

45. Comprehensive Training in Forensic Psychiatry, *Amer. J. Psychiat.*, 31:2, p. 223, Feb., 1974.

46. Commentary on "Group Rape" by J.M. MacDonald in *Medical Aspects of Human Sexuality*, Vol. 8, Feb., 1974, p. 80.

47. "Sex and the Law" and "Other Sexual Deviation," in *Comprehensive Textbook of Psychiatry II*, ed. Freedman A., Kaplan, H., and Sadock, Williams and Wilkins, Baltimore, 1975.

48. Evaluation of Amnesia in Criminal-Legal Situations, *J. of Forensic Science*, Vol. 19, No. 1, Jan. 1974, p. 98.

49. The Anonymous Sex Offender, *Medical Aspects of Human Sexuality*, Vol. VI, No. 3, March, 1972.

50. Informed Consent, Confidentiality & Privilege in Psychiatry: Practical Applications. *Bulletin of American Acad. Psychiat. and the Law*, 2:101-106, June, 1974.

51. Survey of Teaching Programs in Law & Psychiatry, Sadoff, R.L., Thrasher, J.W., & Gottlieb, D.W., *Bulletin of American Acad. of Psychiatry and the Law*, 2:67-72, 1975.

52. Treatment of the Violent Sex Offender, *Int. J. of Offender Therapy*, 1975.

53. Right to Treatment (with Cohen, I. & Cohen, H.L.) *Bulletin of American Acad. Psychiatry & the Law*, 3:59-65 #2, 1975.

54. "Changing Laws and Ethics in Psychiatry," *Bulletin of American Acad. Psychiatry & the Law*, Vol. V, No. 1, pp. 34-40, 1977.

55. "The Insanity Defense: Why it Should be Retained," *J. Legal Medicine*, June, 1977, pp. 31-34.

56. "New Malpractice Concerns for the Psychiatrist," *Legal Aspects of Medical Practice, March, 1978, pp. 31-35.*

57. "Hospitalization for Care or Incarceration?" *Legal Aspects of Medical Practice*, Vol. VI, No. 6, June 1978, pp. 50-52.

58. "Career Directions in Forensic Psychiatry"

59. Weekly Psychiatry Update Series, (Teaching pamphlets), Biiomedia, Inc., Princeton, N.J., 1977-78.

60. "Developing Community Mental Health Center-Criminal Justice System Interactions", *International Journal of Law & Psychiatry*, Vol. I, No. 4, 1978, pp. 427-436,.

61. "On Refusing Treatment: Rights and Remedies", *Advocacy Now*, Vol. II, 1979.

62. "Physician-Patient Sexual Indiscretion", *International Journal of Medicine and Law*, 1980.

63. "Coping with the Legal Onslaught", Changes in the Mental Health Law: Problems for Psychiatrists with Progress for Patients", in *New Directions for Mental Health Services*, 1980.

64. The Future of Mental Health Advocacy, *Advocacy Now*, June 1980.

65. A Psychiatric Study of Violent Behavior in Lifers (with Richard A. Pakola, M.D.), *Bulletin of the American Academy of Psychiatry & the Law*, II, 1974, pp. 58-66.

66. The Psychiatrist & Criminal Law, *Journal of Operational Psychiatry*, Vol. 5, #2, Spring, Summer 1974, pp. 95-100.

67. Risks of State & Private Hospital Psychicatrist [sic] in Involuntary Hospitalization in Re: Right to Treatment, *Bulletin of the American Academy of Psychiatry & the Law*, Vol. 3, #1, 1975, pp. 32-37.

68. Teaching Forensic Psychiatry (with T.P. Thornberry, Ph.D., D.W. Gottlieb & J. Young, M.A.), *Bulletin of the American Academy of Psychiatry & the Law*, Vol. 7, No. 3, 1980.

69. Changes in the Law have improved treatment of the Mentally Ill, *Hospitals*, May 1, 1981, pp. 61-64

70. The Role of the Psychiatrist in Insanity Cases, *Phila. Medicine*, Vol. 79, 1, January, 1983.

71. Ethical Issues in Representation of Mentally Ill Individuals for Commitment, with M. L. Perlin, *Law & Contemporary Problems*, 45: Summer, 1982, No. 3, pp. 161-192.

72. Practical, Ethical Problems of the Forensic Psychiatrist in Dealing with Attorneys, *Bulletin of the American Academy of Psychiatry and the Law*, 1984, Vol. 12, No. 3, pp. 243-252.

73. Comprehensive Survey of Forensic Psychiatrists: Their Training and Their Practices, with C. D. Hanson, P. Sager, J. Dent and D. Stagliano, *Bulletin of the American Academy of Psychiatry and the Law*, 1984, Vol. 12, No. 4, pp. 403-411.

74. Patient Rights v. Patient Needs: Who Decides? *Journal of Clinical Psychiatry*, 44:6, June, 1983, pp. 27-32.

75. Sexual Violence, *Bulletin New York Academy of Medicine*, 62:5, June, 1986, pp. 466-476.

76. Insanity: Evolution of a Medical-Legal Concept. *Transactions and Studies of the College of Physicians of Philadelphia*, Series 5, Vol. 9, No. 4, 1987, pp. 237-256.

77. Ethical Issues in Forensic Psychiatry. *Psychiatric Annals*, May, 1988, pp. 320-323.

78. On Accepting Retainer Fees in Forensic Psychiatric Cases. *The Newsletter of the American Academy of Psychiatry and the Law*, December, 1987.

79. Violence: Roots and Remedies: The Perspective of the Forensic Psychiatrist, *Bulletin of the American Academy of Psychiatry and the Law*, Vol. 16, No. 2, June, 1988, pp. 145-152.

80. Sadoff, R.L., "The Essence of Tarasoff," *Maryland Medical Journal*, 30:55, 1981.

81. Sadoff, R.L., "Family Violence Litigation: What the Examining Psychiatrist Should Know," *The Psychiatric Times*, Vol. 8, No. 2, February, 1991, pp. 39-41.

82. With Gutheil, T. G., "Expert Opinion: Death in Hindsight," in *Review of Clinical Psychiatry and the Law*, Ed. by Simon, R. I., Vol. 1, American Psychiatric Press, Washington, D.C., 1989, pp. 329-339.

83. With Gutheil, T. G., "Expert Opinion: A Case of Tardive Dyskinesia," in *Review of Clinical Psychiatry and the Law*, Vol. 2, Ed. by Simon, R. I., American Psychiatric Press, Washington, D.C., 1990.

84. With Gutheil, T. G., "Expert Opinion: Sexual Exploitation," in *Review of Clinical Psychiatry and the Law*, Vol. 3, Ed. by Simon, R. I., American Psychiatric Press, Washington, D.C., 1991.

85. With Petrila, J. P., "Confidentiality and the Family as Caregiver," *Hospital and Community Psychiatry*, 43:2, February, 1992, pp. 136-139.

86. Therapeutic Jurisprudence: A View from a Forensic Psychiatrist, in *New York Law School Journal of Human Rights*, Vol. 10, Part 3, Symposium, 1993, pp. 825-833.

87. With Halleck, S. L., Hoge, S. K., Miller, R. D., and Halleck, N. H., "The Use of Psychiatric Diagnoses in the Legal Process: Task Force Report of the American Psychiatric Association," *Bulletin of the American Academy of Psychiatry and the Law*, Vol. 20, No. 4, 1992, pp. 481-499.

88. Sadoff, Robert L., "Assessing Disability and Compensation," in *Current Opinion in Psychiatry*, Section on Forensic Psychiatry, November 1995, London.

89. Sadoff, R. L., "Mothers Who Kill Their Children," in *Psychiatric Annals*, 25:10, October 1995.

BOOKS PUBLISHED:

1. *Psychic Injuries*, with Marvin E. Lewis, Esq., Matthew Bender, N.Y., 1975.

2. *Forensic Psychiatry: A Practical Guide for Lawyers and Psychiatrists, 2nd Edition, 1988.* C. Thomas, Springfield, Ill, 1975. (1st Ed.)

3. *Violence and Responsibility*, Spectrum Publ., N.Y., 1978.

4. *Legal Issues in the Care of Psychiatric Patients: A Guide for Mental Health Professionals*, Springer, N.Y., 1982.

5. *Psychiatric Clinics of North America*, December 1983, Vol. 6, No. 3, Forensic Psychiatry, Saunders, Philadelphia, 1983.

6. With Simon, R. I., *Psychiatric Malpractice: Cases and Comments for Clinicians*, American Psychiatric Press, Washington, D.C., 1992.

TAPE RECORDINGS:

1. Behavioral Science Tape Library: "Psychiatry and the Law," Six Cassettes, 1972.

2. Trial Lawyers Tape of the Month: "The Psychiatrist in Civil-Legal Procedures," Autumn, 1971.

3. APA Tape Library: "The Right to Treatment: What It Is and What It Is Not," May 1975.

4. SKF: Psychiatric Recorder: Forensic Psychiatry, Moderator, Panel, 1978.

5. Medical Portfolio for Psychiatrists, Vol. 2, No. 1, Side 2, "The Right to Refuse Treatment," 1981.

6. Videotape recording: Patient Rights v. Patient Needs: Who Decides? Produced by Squibb, May 1983.

7. College of Psychiatrists audiotape on "The Insanity Defense," with James Cavanaugh, M.D., and Richard Ciccone, M.D., 1989.

CHAPTERS IN BOOKS

1. "Sex and the Law" and "Other Deviations," in *Comprehensive Textbook of Psychiatry, II*, ed. Freedman, A., Kaplan, H., and Sadock, B., Williams & Wilkins Press, Baltimore, 1976.

2. "The Psychiatrist and the Rapist: Legal Issues," in *Clinical Aspects of the Rapist*, ed. Rada, R. T., Grune & Stratton, N.Y., 1978

3. "Indications for Involuntary Hospitalization: Dangerousness or Mental Illness," in *Law and the Mental Health Professions*, ed. Barton, W., I.U. Press, N.Y., 1978.

4. "The Mental Health Profession's Role in Patient Advocacy," with Louis Kopolow, M.D., in *Mental Health Advocacy*, NIMH, Washington, DC, 1978.

5. "On the Nature of Crying and Weeping," in *The World of Emotions*, Soccarides, Charles C., Int. Univ. Press, NY, 1977.

6. "Violence in Juveniles," in *The Violent Child, Treatment and Legal Aspects*, ed. Kalogerakis, M.G., Jason Aronson, N.Y., 1978.

7. "Working with the Forensic Psychologist," in *The Role of the Forensic Psychologist*, ed. Cooke, Gerald J., Chas. C. Thomas Co., Springfield, Ill., 1980.

8. "Changes in the Mental Health Law: Progress for Patients – Problems for Psychiatrists in *New Directions for Mental Health Services*, ed. Halleck, Seymour E., Jossey-Bass, San Francisco, 1979.

9. "Adversary Approach to Violent Offenders" with Perlin, M. in *Violence: Perspective on Murder and Aggression*, ed. Kutash, I., Kutash, S. B., and Schlesinger, L. B., Jossey-Bass, San Francisco, 1978.

10. "The Legal Rights & Difficulties of Children in Separation & Divorce," with Stephen Billick, M.D., in *Children of Separation and Divorce: Management and Treatment*, ed. by Irving R. Stuart, and Lawrence Edwin Abt, Nostrand Rinehold Co., N.Y., 1981.

11. "Forensic Psychiatry," in *Forensic Sciences*, ed. by Cyril Wecht, M.D., J.D., Matthew Bender, N.Y., 1983.

12. Legal Issues in the Care & Treatment of Psychiatric Emergencies, in *Psychiatric Emergencies*, ed. by Dubin, W. R., Hanke, N., & Nickens, H. W., Churchill Livingstone, Inc., N.Y., 1983.

13. Psychiatric Malpractice in Forensic Psychiatry: The Plaintiff's Case, in *Critical Issues in American Psychiatry & the Law*, Vol. 2, ed. by Rosner, R., Plenum Press, N.Y., 1985.

14. Malpractice in Psychiatry: Standards of Care and the Expert Witness, in *Psychiatric Malpractice*, ed. by Reid, W. H., Spectrum, N.Y., 1984.

15. "Competence and Informed Consent," in *Legal Encroachment on Psychiatric Practice*, ed. by S. Rachlin, *New Directions for Mental Health Services*, No. 25, San Francisco: Jossey-Bass, March 1985.

16. "The Insanity Defense in Criminal Law," in *Premenstrual Syndrome*, ed. by Ginsburg, B. E. and Carter, B. F., Plenum Publishing Corporation, New York, 1987.

17. "What the Attorney should Know in Using Expert Witnesses in Child Custody Cases," with Schechter, M.D. and Grossman, J. C., and Dunning, B. J., in *Pennsylvania Child Custody* by Bertin, E., Bisel Company, Philadelphia, 1983.

18. "Children Who Kill," in *The Human Side of Homicide*, ed. by Danto, B., Bruhns, J. and Kutscher, A. H., Columbia University Press, New York, 1982, pp. 165-174.

19. Political and Legal Perspectives in *The Premenstrual Syndrome*, Ed. by William R. Keye, Jr., Saunders, Philadelphia, 1988, pp. 15-26.

20. In Defense of the Insanity Defense, in *Critical Issues in American Psychiatry and the Law*, Ed. by Rosner, R., Vol. 5, *Mental Health Services to Courts*, Plenum, New York, 1988.

21. United States Legislation in Forensic Psychiatry, in *Principles and Practice of Forensic Psychiatry*, Ed. by Bluglass and Bowden, Churchill Livingston, London, 1989.

22. "Basic Facts About Mental Illness", in *Legal Rights of Mentally Disabled Persons*, Ed. by P. Friedman, Practicing Law Institute, Washington, DC, 1979.

23. Psychiatric Malpractice, in *Preparing and Winning Medical Negligence Cases*, Ed. by Preiser,

S. E., Wecht, C. H., and Preiser, M. L., Michie, Charlottesville, VA, 1989.

24. Sadoff, R. L., "Medical-Legal Issues," in *Comprehensive Review of Geriatric Psychiatry*, Ed. by Sadavoy, J., Lazarus, L. W., and Jarvik, L. F., American Psychiatric Press, Washington, D.C., 1991, pp. 637-651.

25. "Ethical Issues in Forensic Psychiatry," in *Critical Issues in American Psychiatry and the Law*, Vol. 7, pp. 163-169, Ed. by Rosner, R., and Weinstock, R.: *Ethical Practice in Psychiatry and the Law*. New York: Plenum Press, 1990.

26. Psychiatry and Law (Forensic Psychiatry), ACLM *Medical Legal Primer*, Ed. by Wecht, C. H., ACLM Foundation Press, Pittsburgh, 1991.

27. With Dubin, L. L., The Use of Hypnosis as a Pretrial Discovery Tool in Civil and Criminal Lawsuits, in *Legal Medicine*, Ed. by Wecht, C. H., Butterworths, Salem, NH, 1990, pp. 105-124.

28. With Sadoff, Julie B., *The Impaired Health Professional: Legal and Ethical Issues* in *Psychiatric-Legal Decision Making by the Mental Health Practitioner*, Ed. by Bluestone, H., Travin, S., and Marlowe, D. B., John Wylie & Sons, Inc., New York, 1994.

29. Sadoff, Robert L., *Practical Issues in Forensic Psychiatric Practice* in *Principles and Practice of Forensic Psychiatry*, Ed. by Rosner, R., Chapman and Hall, New York, 1994, pp. 41-46.

FORENSIC PSYCHIATRIC EXPERIENCE

EXPERT WITNESS TESTIMONY

Testified in 20 states, several federal jurisdictions, occasional international consultations.

ACADEMIC PRESENTATIONS

Lectured in most states in the United States and in 12 countries of the world.

EXHIBIT 2

IN THE COURT OF COMMON PLEAS OF LEHIGH COUNTRY, PENNSYLVANIA

COMMONWEALTH OF PENNSYLVANIA Respondent. v. RONALD ROMPILLA Petitioner.	:	No. 682/1988

DECLARATION OF DR. ROBERT SADOFF PURSUANT TO 28 U.S.C. SECTION 1746 AND 18 PA.C.S. SECTION 4904

1. I am a medical doctor licensed in the Commonwealth of Pennsylvania. I specialize in psychiatry.

2. I have no recollection of having evaluated Ronald Rompilla. I understand from review of my letter of September, 1988 addressed to Maria Dantos, Esq. – then employed in the Lehigh County Public Defender's Office – that I saw Mr. Rompilla on September 15, 1988. As a psychiatrist, I do not conduct psychological and neuropsychological testing and would not have done so in Mr. Rompilla's case.

3. I have recently reviewed school records regarding Mr. Rompilla. These records are attached to this Declaration. These records show that as a child Mr. Rompilla scored, in October, 1959, on the WISC, a standardized psychological IQ test, a verbal IQ of 61, performance of 75 and a full-scale of 64, which is in the developmentally challenged (formerly mentally retarded) range. In April of 1957, he had scored a 75 IQ, which is in the low normal range, at age nine. The records also note that Mr. Rompilla was placed in special education classes. In 1961, on the WISC, he showed a verbal IQ of 69, a performance of 75 and a full-scale of 69, which, again, is at the high end of the developmentally challenged. I am told that in October, 1974, his WRAT (Wide Range Achievement Testing) was 27, which, I am told, is in the low percentile. I have no direct experience with the WRAT.

4. I understand that trial counsel testified in post-conviction proceedings that they never obtained any of these materials and therefore they were not provided to me in 1988.

5. I understand from the attorneys that Dr. Gerald Cooke, clinical and forensic psychologist, had worked with me in evaluating Mr. Rompilla. It is my experience with Dr. Cooke that had he had access to these scores, he would have conducted a battery of neuropsychological testing to help assess the cause or etiology of these low scores when Mr. Rompilla was a youngster. It is to be noted that Mr. Rompilla achieved an IQ of 93 in October, 1975. There is clearly a discrepancy between his earlier IQ scores and his later one. It would have been my request to have neuropsychological testing conducted had I been faced with this information that I apparently did not have in 1988, when conducting my examination. The concern would have been

the presence or absence of organic brain dysfunction that may have affected his IQ score.

6. I am presently not available to testify in this latter until late May, 1996. This declaration sets forth my views.

7. I hereby certify that the facts set forth above are true and correct to the best of my personal knowledge, information and belief, subject to 28 U.S.C. § 1746 and 18 Pa.C.S. § 4904.

/s/ Robert Sadoff, M.D.
ROBERT SADOFF, M.D.

Dated: Jenkintown, PA
April 8, 1996

IN THE COURT OF COMMON PLEAS OF
LEHIGH COUNTY, PA CRIMINAL DIVISION

COMMONWEALTH OF PENNSYLVANIA, : No. 682-1988
:
-vs- :
:
RONALD ROMPILLA, :
Defendant. :

DEPOSITION OF FRANK M. DATTILIO, M.D.

Deposition taken in reference to the above matter at the medical offices of Frank M. Dattilio, M.D., 1251 South Cedar Crest Boulevard, Suite 211-D, Allentown, Pennsylvania, 18103, on Tuesday, May 7, 1996, commencing at 10:15 a.m. and stenographically reported by Robyn L. Berner, Registered Professional Reporter.

APPEARANCES:

MICHAEL McINTYRE, ESQUIRE
Assistant District Attorney
c/o Lehigh County Courthouse
5th & Hamilton Streets
Allentown, Pennsylvania 18101
– For the Commonwealth

MICHAEL WISEMAN, ESQUIRE
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437 Chestnut Street – Suite 501
Philadelphia, Pennsylvania 19106
– For the Defendant

* * *

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(610) 366-9088

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[3] DR. DATTILIO: Just for the record, I provided the stenographer with a copy of Dr. Armstrong's report to provide her with a copy of the words that will probably be flying around here, just so you know that. If you have an objection to that, she can return that as soon as she's finished.

MR. McINTYRE: Let's go on the record. This is Mike McIntyre with the Lehigh County District Attorney's Office. We're here in Dr. Dattilio's office in the case of Ronald Rompilla, case no. 682 of 1988. What I'd like to do, first, Mike, is the doctor told me he is unavailable as of 3:00 this afternoon. Now, it's 10:00 right now, or it's 10:15 now, depositions were scheduled at 10:00. Do you think you're going to need more time than that?

MR. WISEMAN: I'm not sure myself. If we run out of time, we'll just pick a convenient time.

MR. McINTYRE: Just so we don't get into a fight about that time being the bewitching hour.

MR. WISEMAN: Let me just say, I'd like to state a general objection on the record to Dr. Dattilio's testimony in this case. In a recent Pennsylvania Supreme Court case, Commonwealth versus Buehl, B-U-E-H-L, which can be found at 658 A.2d 771, in particular, page 781, the Court held inadmissible the testimony of a mental health professional who was giving testimony as to issues in the case, mental [4] health issues, without having examined the subject of his opinions, and the Court specifically held that such testimony was inadmissible.

MR. McINTYRE: Okay.

MR. WISEMAN: So I'd just like to place that on the record. We do object to any opinions this doctor would offer about the issues before the Court.

MR. McINTYRE: All right. We'll take a chance with it.

DR. DATTILIO: Off the record.

(Thereupon, a discussion was held off the record.)

FRANK M. DATTILIO, M.D., having been duly sworn, was examined and testified as follows:

DIRECT EXAMINATION

BY MR. McINTYRE:

Q. Would you state your name, please.

A. Dr. Frank M. Dattilio, D-A-T-T-I-L-I-O, one word, no accent.

MR. McINTYRE: Mike, I guess we should put on, we're under the same rules we've been under for the other depositions, you have to state your objection.

MR. WISEMAN: Yes.

BY MR. McINTYRE:

Q. What is your occupation?

A. I'm a clinical psychologist.

[5] Q. What is your address?

A. Suite 211-D, as in David, 1251 South Cedar Crest Boulevard, Allentown, Pennsylvania, 18103.

Q. Do you have any specialties?

A. Yes, I do. My specialties are clinical psychology, cognitive therapy and behavior therapy.

Q. Are you board certified?

A. I am.

Q. With who?

A. With the American Board of Professional Psychology and in Behavioral Psychology.

Q. I'm going to show you what's been marked as P-3, Commonwealth 3, excuse me.

MR. WISEMAN: I see you're marking it.

MR. McINTYRE: Right, I called it P-3. There's 1 and 2 that were entered at some other time in this case.

BY MR. McINTYRE:

Q. I ask if you can identify this.

A. Okay. This is a complete and updated version of my curriculum vitae.

Q. Is that accurate?

A. Yes, to the best of my knowledge.

Q. Okay. Dr. Dattilio, have you had an opportunity to review various documents in regard to the case of the Commonwealth versus Ronald Rompilla?

[6] A. Yes, I have.

Q. Now, have you seen a statement from Dr. Barry M. Crown dated November 29, 1995?

A. Yes, sir.

Q. And have you seen a report from Dr. Carol Armstrong dated March 5th, 1996?

A. Yes.

Q. Have you seen a report from Dr. Paul Gross dated June 4th, 1988?

A. I have.

MR. McINTYRE: And for the record, that Dr. Gross report would be exhibit D-1 in this case, the Dr. Gross report.

BY MR. McINTYRE:

Q. All right. Have you also seen grade school records from Mr. Rompilla?

A. Yes, I have.

MR. McINTYRE: Now, maybe you could help me out with this, Mike. I'm not exactly sure what exhibit they were in the case. I have them as D-5.

MR. WISEMAN: Sure. I'll tell you in a second. The school records were initially marked as Defendant's 4 and 5, and I believe that the authenticated version where a custodian was brought into court was actually D-8. I think that's how we've been referring to them.

[7] BY MR. McINTYRE:

Q. Have you seen a hospital record for Mr. Rompilla back in 1988 from the Sacred Heart Hospital?

A. Yes, I have.

MR. McINTYRE: And can you help me out with that, Mike. I'm at a loss as to what exhibit that is in this case. I have it as D-4.

MR. WISEMAN: Sure. I have it as D-6.

MR. McINTYRE: Okay. What I have as D-6 is the next exhibit that I'll ask the doctor about.

BY MR. McINTYRE:

Q. The initial transfer petition from the Commonwealth of Pennsylvania, have you seen that?

A. Yes.

MR. WISEMAN: I have that as D-7. I think we all know what we're talking about.

MR. McINTYRE: Just so we have all these numbers right.

BY MR. McINTYRE:

Q. Doctor, did you have the opportunity to examine Mr. Rompilla?

A. No, I did not.

Q. Did you have the opportunity to review depositions of Dr. Crown or Dr. Armstrong?

A. No, I did not.

[8] MR. McINTYRE: For the record, Mike, I don't believe those depositions have been transcribed, at least I don't have them.

MR. WISEMAN: You don't?

MR. McINTYRE: Do you have them?

MR. WISEMAN: Yes.

MR. McINTYRE: When did you get them?

MR. WISEMAN: I don't know the exact date. I've had them for probably – which ones, of Crown and Armstrong?

MR. McINTYRE: Yes, those two.

MR. WISEMAN: I'd say I have them for about ten days or so. I thought you were getting copies of them.

MR. McINTYRE: I haven't received them.

MR. WISEMAN: Okay.

THE WITNESS: Also, I want to state for the record I've not had the liberty of reviewing any of the raw data, test data, from either Dr. Crown or Dr. Armstrong's evaluation.

BY MR. McINTYRE:

Q. You've just seen the reports?

A. Only the reports.

MR. McINTYRE: I guess we ought to have for the record, let's see if we can find out what exhibits those are. We marked those both as exhibits, Armstrong's report and Crown's report. I think you did. Let's just double [9] check that.

MR. WISEMAN: Armstrong's report is Defendant's 18. Dr. Crown's report was attached to the – Dr. Crown's statement was attached to the initial P.C.R.A. petition. I think it was marked as D-16.

MR. McINTYRE: All right. I agree with those.

BY MR. McINTYRE:

Q. Pursuant – did you read over all those documents that you had then?

A. I did.

Q. And did you then receive from me a request for certain questions?

A. I did. It was a three page request dated April 8th, 1996.

Q. And did you answer those questions in a report form?

A. To the best of my ability, I did.

MR. McINTYRE: And I believe counsel has received that report.

MR. WISEMAN: Yes, Friday afternoon of this past week we received that.

MR. McINTYRE: All right. I'm going to offer Dr. Dattilio as an expert on the question of whether or not any expert, including Crown and Armstrong, can render an opinion based on an examination and test results from 1995 [10] and 1996, along with the other items of evidence which we've just gone over, as to whether or not Mr. Rompilla evidenced any problems under the sentencing code in regard to mitigation in a capital offense at the time of the commission of the offense back in January of 1988. You may question him on those qualifications.

MR. WISEMAN: Are you offering Dr. Dattilio, then, as an expert in capital mitigation from a forensic setting, forensic perspective?

MR. McINTYRE: I don't know if its necessarily you have to say that. I'm offering him as I indicated to you. I can't make it more clear. He's going to be asked whether or not he has an opinion as to whether any expert can retroactively relate back from testing done eight to nine years later, whether a person's mental condition – what it was eight to nine years earlier.

MR. WISEMAN: I would object as to the form of the offer. I don't think you can offer an expert as to one of the ultimate issues in the case. You can offer him as an expert, obviously, in a learned field.

Let me ask a few questions in addition to that.

MR. McINTYRE: Sure.

CROSS EXAMINATION ON QUALIFICATIONS

BY MR. McINTYRE [sic]:

Q. Do you have any neuropsychological expertise?

[11] A. I have some experience in neuropsychological testing and supervision.

Q. Are you board certified in any form for neuropsychology?

A. No, I am not.

Q. Just bear with me a moment.

A. Sure.

Q. Are you a member of the American Board of Professional Neuropsychology?

A. I am a member of the American Board of Professional Psychology.

Q. How about professional neuropsychology?

A. No.

Q. Are you a member of the National Academy of Neuropsychology?

A. No.

Q. American Academy of Neurology?

A. No.

Q. International Neuropsychology Society?

A. No.

Q. American Society of Neurorehabilitation?

A. No.

Q. You're a clinical psychologist?

A. Yes.

Q. And your practice is primarily in the area of [12] marriage and family therapy?

A. No, not only.

Q. Well, I said primarily.

A. No.

Q. It's not primarily?

A. No.

Q. Your letterhead lists the American Association for Marriage and Family Therapy.

A. Yes, that's correct.

Q. What other areas do you practice in?

A. Clinical psychology, psychodiagnostic evaluations, forensic evaluations.

Q. In your report you mention that you're on the staff of the Department of Psychiatry at the University of Pennsylvania School of Medicine?

A. That's correct.

Q. And would that be as a clinical associate at the Center for Cognitive Therapy?

A. That's correct.

Q. That's not a paid position, is it?

A. No.

Q. That's a volunteer position?

A. That's correct.

Q. How long have you held that position?

A. Since 1986.

[13] Q. Does that position involve issues of neuropsychology?

A. No.

MR. WISEMAN: I would object to Dr. Dattilio being offered as an expert in this case. The issues that are before the court are neuropsychological issues, and I think Dr. Dattilio clearly is not an expert in neuropsychology. He's an expert in clinical psychology; and I think he is not, therefore, credentialed to make the comments you have offered him to make as an expert, and I would note my objection on that basis.

MR. McINTYRE: Okay. No more questions on his qualifications?

MR. WISEMAN: No.

CONTINUATION OF DIRECT EXAMINATION

BY MR. McINTYRE:

Q. Doctor, I want to ask you some questions similar to the ones I posed which you answered in the report that you filed in this case.

I guess we should begin – we'll call them reports, although Dr. Crown's wasn't technically a report; but the

narratives you read from Dr. Crown and Dr. Armstrong, have you familiarized yourself with those?

A. Yes.

Q. First of all, what did Dr. Crown indicate in his [14] statements?

A. Well, he indicates that – first of all, it wasn't clear to me as to exactly what this was. It appeared as though it was almost in a deposition form, but I wasn't sure whether or not he had submitted this as a formal report.

He indicated that he had administered a number of tests and reviewed background information. He also indicated that he had performed a clinical interview with Mr. Rompilla. He states in here that he administered – just bear with me for a second, please – the Wide Range Achievement Test and, also, I believe he said he administered the Wechsler Adult Intelligence Scale.

Q. Let me ask you this. Does he report anywhere in that the score that Mr. Rompilla achieved?

A. No. Surprisely, no. In fact, there are no scores indicated here at all.

Q. All right. Is that unusual?

A. Yes.

Q. Why do you say that?

A. Our ethics of psychology say if we administer any tests psychological in nature, educational tests, that we must, if those tests are valid and reliable, we report the scores, the interpretation and the findings of that.

Q. Are there different ethics for a neuropsychologist than there are for a psychologist?

[15] A. No.

Q. I take it neuropsychology is a subspecialty of psychology?

A. That's correct.

Q. How about Dr. Armstrong's report, does she give test results?

A. Yes, she does. Dr. Armstrong again, while this is a thorough report of the findings, it's a little bit unusual in that typically the background information and history is stated first leading up to the reason why the evaluation was requested. Then there's usually a listing of tests that were administered, which she has on page two and page three respectively. Then usually they will go into the findings of the test results, which she's listed just for quick citation here, and then they usually draw conclusions, which she has done at the end.

Q. Can you tell from Dr. Armstrong's report whether or not she administered any tests that we know as an IQ test?

A. Yes. Actually, what Dr. Armstrong administered was several cognitive tests, the Logical Deductive Reasoning Test, a test on Cognitive Flexibility and a Written Calculation. She also administered selective subtests of the Wechsler Memory Scale, Digit Span, Visual Memory Span and Logical Memory Test I.

[16] Q. Okay. Did she give any numerical scores for the results of those tests?

A. No, she failed to state a verbal performance IQ as well as a full scale IQ, which, again, is a little surprising to me as to why she would have gone through the efforts of the tests.

Q. And do you know from your reading of the reports from Drs. Crown and Armstrong that there is a lot to do in this case with prior IQ tests of Mr. Rompilla, his grade school IQ tests?

A. It appears so.

Q. Would you know of any reason why neither of these doctors would list the scores that they administered?

A. I'm at a loss as to why they haven't.

Q. Okay. Now, let me ask you this. Can you conclude anything to a reasonable degree of psychological certainty from Dr. Crown's statement about Mr. Rompilla's condition?

A. Can I conclude anything?

Q. To a reasonable degree of psychological certainty.

A. Well, no, it's hard for me to do that because he seems very vague in his report with respect to where he derived certain information; and he uses information that was administered from tests previously, and I would be leery to derive anything directly from that.

Q. Let me ask you the same question about Dr. [17] Armstrong's report. Can we conclude – and listen closely to this question – first, initially from Dr. Armstrong's report, and tell us from the results whether or not Mr. Rompilla had some type of a mental problem or had some

type of a mental problem at the time of his testing in early 1996?

A. I think it's very difficult for us to infer from the results and conclusions of her test that at any time specificity can be placed on any brain damage that occurred with this gentleman.

Q. Well, do we know, can we conclude there was one at the time she examined him and tested him?

A. I think that clearly her findings are accurate, that he did indeed have brain damage at the time she evaluated him.

Q. Now, the next question is, can we conclude when that brain damage occurred?

A. Not with any degree of accuracy, no.

Q. Can we conclude to a reasonable degree of psychological certainty when the brain damage evidenced by the testing done by Dr. Armstrong in 1996 occurred in Mr. Rompilla?

A. No.

Q. Can we conclude with any reasonable degree – strike that – to a reasonable degree of psychological [18] certainty what caused the problems evidenced by Dr. Armstrong's testing in 1996?

A. From what I've gathered from the reports and the background information, not clearly, no.

Q. Is there more than one possible cause of the type of damage that shows up in this testing by Dr. Armstrong in '96?

A. Based on what I've read and all the information, yes.

Q. What types, what can cause this problem?

A. First of all, we're talking about a number of factors that occurred over a long span of time. There's a history of alcoholism, not only Mr. Rompilla himself but with his biological mother. There's a conflictual history about blows in the head that he sustained between what's reported by Dr. Crown and Dr. Armstrong and what was reported years ago by Dr. Gross. Again, depending on when those incidents occurred, we might be able to try to pinpoint some things, but it's very difficult to do.

Q. A history of alcoholism is a possible cause of this type of brain damage?

A. Could be.

Q. How about head injury?

A. Could be.

Q. How about – and I have no idea about this one – [19] how about prolonged periods of incarceration in a state penitentiary?

A. Depends on what happened during those prolonged periods. If there were documented fights or nondocumented fights in which he sustained any kind of damage to his head, if there was any indication of any substance use, homemade or whatever, that occurred during the time in which he was incarcerated and plus, you know, the normal course of deterioration of one's mental and physiological state over time in certain circumstances.

Q. All right. Before I ask you about that, the aging process, what about – and what I was throwing out here, and I have no idea about it, is the fact that a person has been incarcerated alone, not that he then got into a fight. Mr. Rompilla, you know from the records, was incarcerated from '76 through '87, and then he got out for a short time, committed this offense in January of '88, and went back in from '88 to '95, when he was first tested by Crown. Any studies on that?

A. If anything, what Mr. Rompilla would have probably been affected by is his emotional status as a result of his incarceration; and depending on the circumstances, that may have some impact on his functioning. What's interesting is neither Dr. Crown or Dr. Armstrong seemed to administer any type of projective psychological testing or any MMPI test, [20] which would give us more of a clue into his psychodynamics and the emotional state of his condition.

Q. Now, let's talk about the aging process. Mr. Rompilla, if I'm not mistaken, is going to be 48 this year, I think in November?

A. According to the literature, that's correct.

Q. Now, does the aging process affect out mental status?

A. Yes, over time.

Q. How does that – can you expound on that?

A. Well, with any aging process, there's deterioration of functions. It's different for everyone, but usually at age late 40's or 50's, there's not necessarily too much deterioration. It usually occurs in the last third of a person's life.

Q. All right. You say usually. Is it possible that a change can occur in a person's mental status from age 40 to age 48?

A. It's possible.

Q. Is it possible that that can occur to a person who's facing a death sentence and is incarcerated during that period of time?

A. It's possible that there would be deterioration in his mental status.

MR. WISEMAN: I'm going to object to these last [21] two questions in regards to possibilities as opposed to certainties.

MR. McINTYRE: I think you missed the first one, but okay. It's noted.

BY MR. McINTYRE:

Q. Let me ask you this concerning alcoholism. Does the use of alcoholism [sic] instantaneously cause brain damage? The fact that the heavy use of alcohol, does that instantaneously cause brain damage, or does that happen over time?

A. Normally, it happens over time.

Q. All right. Now, let me give you an example. What if I was a heavy drinker to age 30, and age 30 I had no brain damage, and then I stopped drinking. Would that heavy drinking of alcohol affect me later in life?

A. It depends.

Q. On what?

A. Well, a number of factors. It depends on the predisposition of your condition prior to drinking and during the time that you're drinking. We don't know what's always going on inside of the brain just by virtue of the way an individual functions. It may have accelerated a pre-existing deteriorative state that may have later manifested. That's a possibility.

Q. So the manifestation of the problem doesn't have [22] to occur at the time of the drinking; it could occur later?

A. It's possible.

Q. Okay. Now, would it be important for any expert, including Crown and Armstrong, to know what was going on with Mr. Rompilla from the time of his incarceration in 1988 until the time of their testing in 1995 and 1996?

A. I would think it's not likely.

Q. All right. Let me try that question again. Would it be important for them to know what happened to him when he was in prison during that period of time?

A. I would think so, yes.

Q. You understand what they've done is they've used their test results of 1995 and '96 to render an opinion as to what his mental status was at the time of the crime?

A. That's the impression I received.

Q. In order to do that, is it important for a person to know what has happened to him in the intervening years between the crime and their testing?

A. If I were doing the evaluation, that's what I would want to know.

Q. Did you note from either of these doctors any suggestion that they got any type of a history from Mr. Rompilla or anyone else as to what happened to him in those eight years, from 1988 to 1995, 1996?

A. While incarcerated?

[23] Q. Yes.

A. Not that I recall.

Q. Let me ask you this, Doctor, and then I'll ask you some small questions, but I'm going to ask you basically the crux of my questions today, and actually I wrote it out for you, and then we'll ask you some small questions as to your opinion.

First of all, I want to know if you have an opinion to a reasonable degree of psychological certainty, and I'll ask you what that opinion is, okay?

A. Yes.

Q. Do you have an opinion, to a reasonable degree of psychological certainty, as to whether or not any expert has the ability to render an opinion to a reasonable degree of psychological certainty as to Mr. Rompilla's mental state on the date of the murder in January 1988 based solely on exams and testing done in 1995 and 1996?

A. Yes, I have an opinion.

Q. What is that opinion?

A. Based on your statement, it is my contention that it is very difficult for anyone to retroactively determine whether or not that existed at the time.

Q. All right. Now, when I talk about mental state, I want to ask you specifically this, and I'm going to read for the record from the sentencing code, and I want to know [24] whether or not in that same question these experts can opine to a reasonable degree of psychological certainty as to whether or not at the time of the crime the defendant manifested either of these conditions: Number one, the defendant was under the influence of extreme mental or emotional disturbance; and, number two, the capacity of the defendant to appreciate the criminality of his conduct or to conform his conduct to the requirement of law was substantially impaired. Do you have an opinion?

A. Yes.

Q. And what is that opinion?

A. The opinion is that they would have had to have first-hand information about the environment, the circumstances, individuals who witnessed his behavior, emotional displays that were credible, or having had witnessed it themselves first-hand in order to render that kind of an opinion.

Q. All right. Let me ask you this, whether or not the availability of any of the other information that Dr. Crown and Dr. Armstrong had would change your opinion about their ability to render that opinion in the first place.

Let's take these one at a time. Let me show you something that I haven't shown you before, and it's not one of the things you've seen. This is Defense Exhibit No. 20. [25] I believe I can state these are some testing [sic] done

on Mr. Rompilla in 1988, December 9th, 1988, almost a year after the offense for which he was convicted, and just take a look and study that.

For the record, I haven't shown the doctor that.

A. Okay.

Q. Assuming that that test was done on Mr. Rompilla, those tests – first of all, let me ask you some questions. Wasn't an IQ test done on him in December of '88 based on that exhibit?

A. They said he earned a 79 on the WAIS, Wechsler Adult Intelligence Scale. I assume they mean an IQ scale of 79, which borders on low average.

Q. That is not in the retarded range, is it?

A. It's in the high end of the borderline range, and that score and that test scale borderline went from 70 to 79 with 80 starting the category of low average, so he was at the crest of the borderline, the high end crest of the borderline range just one point shy of low average.

Q. What does that tell us about his ability to function?

A. That he can function in some circumstances reasonably well, that he's not, you know, a very bright individual, but he's certainly able to get about, hold a job, work in certain positions, recall things to a [26] reasonable degree.

Q. All right. Is that consistent or inconsistent with a finding – strike that. Let me rephrase that question.

That score of 79 on the WISC test, is that any –

MR. WISEMAN: You mean WAIS.

BY MR. McINTYRE:

Q. I'm sorry, WAIS. Is that any evidence of the mitigating circumstances that I indicated to you before, number one, the defendant was under the influence of extreme mental or emotional disturbance? Take that one, is there any evidence of that from that score?

A. It's hard to draw any conclusion just from that score. I would want to see the whole subscale scatter. There may be dips, low dips in the subscales; but basically, I mean, that doesn't suggest that anyone is under any extreme mental stress.

Q. How about the second one, the capacity of the defendant to appreciate the criminality of his conduct or to conform his conduct to the requirements of law was substantially impaired?

A. Clearly with an IQ of that level, the individual is capable of understanding.

Q. Is capable?

A. I'm giving you a rough response to that score [27] alone. Again, I haven't seen the subscale scatter of that test; but, you know, individuals of that score category have been able to do that.

Q. Were there any other scores reported on that documents [sic]? The Jastak Wide Range Achievement Test otherwise known as the WRAT, reading score of 40, spelling of 67 – I'm sorry, strike that. A reading score of 40, which puts him in a one percentile.

A. That's all I see.

Q. Is that indicative of either of those two mitigating circumstances that I've indicated to you? Is that any hard evidence?

A. No. Not by itself, no.

Q. Is there anything on that report, D-20, indicative of the testing done on him, a little bit less than a year after the murder in this case, which would indicate to you that either of those mitigating circumstances were present at the time of the commission of the offense?

A. Not based on this limited information, no, but I'm going to underscore the term limited because it is a limited amount of information, okay. It's very, very superficial.

Q. All right. Now, you've seen the report from Dr. Paul Gross dated June of 1988, correct?

A. I have.

Q. Is there anything in that report which indicates [28] to you that there may have been mitigating circumstances presented on behalf of Mr. Rompilla at the time of the commission of this offense?

A. No. In fact, this is what sparked some of my concern about what was being said in the most recent reports by Drs. Crown and Armstrong. There's conflict in terms of what Mr. Rompilla reports with respect to his history as opposed to what was described in the reports of Dr. Armstrong and Dr. Crown.

Q. Can you be specific?

A. Yes. I'll refer you to page three of Dr. Gross' report.

Q. And what does that indicate?

A. You know, just give me one second, please.

Okay. I'm sorry. I'm going to refer you to page two of Dr. Gross' report. About midway down, the fifth paragraph, there is no history of psychiatric illness or treatment from Mr. Rompilla. He has not spoken to a psychiatrist except for a brief interview prior to parole. He has no history of any medical or surgical problems. He has never been in a hospital. He denies any head injuries.

The second paragraph down, last three lines, he denies any abuse, physical or sexual, while growing up. He left school in the ninth grade because he wanted to work. He says he can read and write.

[29] Q. All right. Now, Doctor, are you aware that Mr. Rompilla was examined by a psychologist by the name of Dr. Gerald Cook in 1988?

A. Yes.

Q. Are you aware Dr. Cook performed four psychological tests on him?

A. Yes.

Q. Are you aware that they were, I believe, the MMPI?

A. That's my understanding.

Q. The Rorschach?

A. Yes.

Q. The Incomplete Sentence?

A. Yes. Well, Sentence Incomplete.

Q. Wechsler IQ?

A. Yes.

Q. And are you aware that Dr. Cook at that time found no evidence of any mitigating circumstances?

A. That's my understanding.

Q. And are you aware that he was also seen by a psychiatrist, Dr. Robert Sadoff, for the same issue, as to whether or not he evidenced any of the mitigating circumstances?

A. Yes.

Q. Are you aware Dr. Sadoff also found nothing?

A. Yes.

[30] MR. WISEMAN: I would object to the characterization, your characterization, Mr. McIntyre, that Dr. Cook and Dr. Sadoff found nothing.

MR. McINTYRE: I think that's the testimony.

MR. WISEMAN: I don't think that was the testimony. It may be your spin on the testimony.

MR. McINTYRE: Would you like to correct it on the record here? Maybe we can agree as to what they found.

MR. WISEMAN: I guess what I'm thinking is perhaps you can ask the witness what the witness is basing his conclusion on that they found no mitigation. That's all. I'm just objecting to your leading question, I guess is the proper objection.

MR. McINTYRE: All right.

BY MR. McINTYRE:

Q. That's your understanding, I take it, though, what these experts found at the time of the trial?

A. That's correct.

Q. Or shortly before the trial, for the record.

Is D-20, this testing that was done on 12/9/88, a little after a year after this incident and I guess a little bit after the trial, is that consistent with those opinions given by Dr. Gross, Dr. Sadoff and Dr. Cook?

A. Yes.

Q. All right.

[31] MR. WISEMAN: Again, I would object to the question, which assumes that they had an opinion, that you're asking the witness if the exhibit's consistent with an opinion. It's now been expressed on the record, and I think it's your view of what the doctor may or may not have found.

BY MR. McINTYRE:

Q. Okay. Let me show you what's been marked, I have D-6, but I think Mr. Wiseman said D-7. This is the initial transfer petition. You've seen that, correct?

A. Yes.

Q. And I believe that's from 1975 or '76?

A. '75/'76, correct.

Q. And does that – at that time was Mr. Rompilla tested, according to that document?

A. According to this, yes.

Q. And as far as you know, prior to the incident, which occurred in 1988, this would be the first earliest date before the incident that he was tested?

A. Correct.

Q. What kind of test was he given there in that exam?

A. Okay. According to this, he was administered intelligence testing on the Beta on 10/15/75, which he had a score of average range.

Q. And what number was that?

[32] A. I don't see a number here.

Q. All right. Turn, I think it's on the next page.

A. Okay. Beta IQ is 93, which places him in the average range.

Q. Do you know anything about this particular IQ test known as the Beta?

A. It's an alternative to the WAIS scales, the Wechsler scales. It has fairly good validity and reliability.

Q. Is there any way you can equate that to the scores in the Wechsler? We talked about the 1988 test. I'm sorry, that was the WAIS. Can you relate it to the WAIS?

A. I don't know what the correlational values of those two tests are, so I'm going to have to say, no, I can't.

Q. So you don't know whether a 93 is equivalent to a 79 in the WAIS?

A. Yes.

Q. You do know the 93 from the Beta indicates average intelligence in 1976?

A. That's correct.

Q. How about other tests?

A. Wide Range Achievement Test was administered, and he obtained raw scores of 47 on reading, spelling was 10, and arithematic [sic] was 13, which yielded scale scores of 93, 73 [33] and 71 respectively; and so this equals a reading level of seventh grade seven months, a spelling score of third grade seven months, and an arithematic [sic] score of third grade four months.

Q. Were there any other tests besides the Beta and the Wide Range Achievement Test?

A. Yes, the MMPI was also administered.

Q. Let's talk about the MMPI tests. Are there results there that indicate things to you from those tests, the MMPI?

A. Yes.

Q. First of all, is there anything in the MMPI test that goes to whether or not in 1976 Mr. Rompilla was suffering from any type of mental problem that would have been evidence of those two mitigating factors that we've mentioned before?

A. Which were, again?

Q. Let me read them to you so we're right on this. Number one, the defendant was under the influence of extreme mental or emotional disturbance; and number

two, the – capacity of the defendant to appreciate the criminality of his conduct or to confrom [sic] his conduct to the requirements of law was substantially impaired.

A. Okay. According to what I'm reading, I'm looking at scaled scores of the MMPI, and I'm going to go through [34] them quickly, okay, the L, F and K scales, which are validity scales – when we talk about within normal limits, we're talking about any scale that's below a T of 70. So for example, on the L scale, he has 60, F is 64, and K, which measures defensive, is 62. These fell within the normal limits, which we'll say he was being reasonably honest and not biased in portraying himself in either a negative or positive light, that he was relatively honest when he was doing this.

The scale measuring hysterionic [sic] personality characteristic is 82, which is elevated. That suggests he has the tendency to engage in overdramatized behaviors, seeks excitement and attention from others. Depression was 65, a slight elevation but wasn't too depressed till you're under 70. His hypochondriacal scale was 76.

Q. What does that mean?

A. His tendency to be anxious, agitated, a hypochondriac, body symptons [sic] elevated. His psychopathic deviate scale was 100. It was off the chart.

Q. What does that tell us?

A. He's a full blown sociopath.

Q. What's that?

A. Has absolute disregard for rules, regulations, the rights of others, just acts on impulse, acts on his own need.

[35] Q. Can you be higher than 100?

A. No. He scraped the top of the scale, and that's with a validity scale being within tact. He's a wavering sociopath.

Q. Do you have an opinion as to whether or not that would have been helpful or harmful to Mr. Rompilla if any expert produced those records and used those records during his portion of his trial when he was attempting to show mitigation?

A. In 1988?

Q. Yes.

A. Yes, this would have been extremely disruptive to his case.

Q. All right.

A. The next scale is the Mf, which measures masculine/feminine profile. That's basically within normal limits, a 53. The scale measure paranoia, which is 82, was elevated, so there's paranoid characteristics that accompanied his sociopathic scale. Pt is the psychoasthenia scale, which measures anxiety, slightly above 70. 73 was the score. Schizophrenia scale was a 90. Okay, that measures his ability to – his tendency to deviate from normal thinking patterns and styles, and that was significantly elevated, and also the mania scale, which is 66, not too terribly elevated.

[36] Q. Do any of those test results, Doctor, affect your, what I'll call your bottom line opinion in this case as to the inability of an expert with testing and examination in 1995 and '96 opining that Mr. Rompilla had evidence of

mitigating circumstances at the time of the offense in 1988?

A. This information would have certainly been useful to someone making a firm decision. I don't know specifically how they would have utilized this information. I'd have to think about that a little bit.

Q. Let's see if I can put it in a simpler way. Does that in any way help or hinder that call based on 1995, 1996 testing to opine what his condition was back in 1988?

MR. WISEMAN: Objection to the form.

BY MR. McINTYRE:

Q. I'll let it stand.

A. Okay. Well, it certainly gives a profile on the man's personality, and it would be important to factor in the scales that were elevated with the results that they're finding and take a look at the correlations with individuals who supposedly have brain damage and what the profiles of the MMPI would show. There are textbooks and research data which talk specifically about correlational factors between different tests; so that studies have been done to say that if individuals evidence brain damage or brain injury of certain areas or functions, that correlation with other [37] tests will be high, and I don't know exactly what it would be in this particular case, but it certainly would have been meaningful information for them to look at.

Q. Okay. But does it help one rendering an opinion concerning the two mitigation factors we talked about?

A. Oh, yes. It suggests that he was capable of understanding what he did.

Q. So that it doesn't help buttress an opinion that he had this evidence of mitigation in 1988?

A. That's correct.

Q. In fact, doesn't it do just the opposite with that elevated area in the sociopath?

A. Yes, sociopathic deviate scale.

Q. What does that indicate in regards to mitigation or aggravation? Strike that. What does that high level indicate as far as these two mitigation factors we talked about, if anything?

A. Well, it underscores the notion that escapable of acting out and – acting on impulse, that he would possibly disregard rules and regulations and lie.

Q. In a sociopathic personality type, is that like voluntary, though, like you deliberately know what you're doing?

A. Yes. Most of the time, yes.

Q. All right. Let me show you the grade school IQ [38] tests which, again, I think I've called it P-5, but we have it on the record exactly what number it is. And you have taken a look at that, have you not?

A. Yes.

Q. All right. Now, I said P, it was D. By the way, there is a report of the three different IQ tests, '57, '59 and '61, 1957, 1959, and 1961?

A. Yes.

Q. I take it at the oldest he is thirteen, 1961?

A. That's correct.

Q. Generally, how reliable are these grade school IQ tests?

A. Well, they're as reliable as they are today. I mean, he was given the standard WISC. Since then, there's the WISC-R, which is WISC Revised, and WISC III, which we currently use. In '57 his full scale IQ was 75.

MR. WISEMAN: You mean his verbal, don't you?

THE WITNESS: Right, verbal score of 75, and then his verbal and performance were given in '59. Verbal was slightly lower. No, actually, I'm sorry, that's about 14 points lower, so that's a significant drop, and performance score was 75, yielding a full scale IQ of 64.

BY MR. McINTYRE:

Q. All right. Let me show you items I've had marked as P-4, P-5 and P-6. It seems to me that they're separate [39] sheets, and you haven't seen these before. It looks like they're the results of what's on the Exhibit D-5 on the grade school IQ's. Can you confirm by looking at each one and making certain that one was accurately transposed on to the other. First of all, I guess you're looking at P-4 right now. Does that look like the 1957 WISC test that was administered to Mr. Rompilla?

A. Yes, April 1957.

Q. Would you just take a moment to see if it's been accurately transposed from P-4 on to D-5?

A. That's correct, verbal scale score's 30, and then the full IQ or the verbal IQ scale score is 75.

Q. Is there any more information on P-4 than is on D-5? In other words, is there any more information in the documents in your left hand that has been transposed on to the documents on your lap?

A. No, only one note, many replies, very irrelevant.

Q. Do you know what that means?

A He may have rambled, and sometimes things didn't necessarily make sense.

Q. Now, look at P-5 underneath it, that would be the '59 test, Can you do the same thing for that, make sure it's been accurately transcribed on to D-5 that's on your lap?

A. Yes, that's correct.

[40] Q. And is everything that's on P-5 been transposed on to D-5?

A. Yes; it appears that way.

Q. Would you do the same thing for the IQ test done in 1961, which is P-6, the last paper you have in your left hand.

A. Yes. Okay, this gives us a little bit more than the previous one. Verbal IQ of 69 and performance scale of 75 with a full scale of 64, and it tells me that there's a 13 or 14 point spread between the verbal and performance score, which suggests there's more to do with academic impoverishment than anything else, particularly in the performance scale in looking at the scaled scores here, 9, 8, 5, 5, 5.

Q. What do you mean it has more to do with academic impoverishment than anything else?

A. When there's any kind of brain damage, we usually will notice that there is a lower performance scale score with specific dips and subtest scores on the performance test than on the verbal test.

Q. What do we know here?

A. Well, its the opposite, so there's no suggestion that he wasn't paying attention in class or applying himself or really learning the information, and that if he were up to par academically, he might have a higher IQ score, which [41] puts him more in the borderline range than this verbal score would put him in the mentally retarded range at that time.

Q. All right. Is there anything about either of those exhibits, P-4, 5 and 6 or the reports of those IQ tests as indicated on D-5 which change your opinion in this case?

A. No. I'm looking at the scaled scores. It gives me additional information there, but other than that, no.

Q. Is there anything on these grade school IQ tests done in 1957, '59 and '61 that would show that Mr. Rompilla evidenced either of the two mitigating factors that we've talked about throughout this deposition at the time of the commission of this offense in 1988?

A. No.

Q. All right. I'll take those back from you, Doctor. Let me show you the hospital records from Sacred Heart Hospital dated, I believe – if I can find them exactly –

March of 1950. I believe Mr. Rompilla would be about a year and a half old. Have you seen these?

A. Yes.

Q. What do they indicate, if you know?

A. They indicate some blood work was done with him; and from what I could gather – it was very difficult to read – that he had been admitted with some fever, I believe.

[42] Q. Did you see a temperature of 105 at some point?

A. Yes.

Q. And did you see complaints of diarrhea?

A. Yes.

Q. What, if any, value does that have in aiding us to reach a conclusion in this case as to what Mr. Rompilla's mental capacity was at the time of the commission of this offense?

A. There's nothing profound about what I've read in here that would suggest that he sustained any particular trauma, other than the fact he had a fever and some diarrhea.

Q. Does every child of about a year and half old that has a 105 fever and diarrhea have brain damage?

A. Not that I'm aware.

Q. Do you know of any significant percent of those children who have high fevers and diarrhea that develop brain damage?

A. Not offhand, no.

Q. Does that change your opinion in this case?

A. No.

Q. The fact that he was hospitalized in March of 1950 –

A. No. In fact, they discharged him without any follow-up, from what I can see. There was follow-up on [43] 3/9/50, and it said one BM in 24 hours, temperature normal, he presents no abnormalities.

Q. All right. I'll take that back, Dr. Dattilio.

Dr. Dattilio, are there objective tests that can be done to determine whether or not a person has brain damage?

A. When you say objective –

Q. Yes.

A. What are you referring to?

Q. Something that doesn't require questions and answers from a defendant, let's ask that, from a person?

A. There are, yes.

Q. Things like a CAT scan?

A. CAT scan, MRI.

Q. Anything else?

A. EEG.

Q. How do those work, each one at a time.

A. EEG is an electroencephalogram, which measures brain waves and brain activity. A neurologist administers it, would look for abnormal spiking and brain waves or any abnormal activities. Two versions can be given, either an awake or an asleep EEG.

CAT scan stands for computerized axial tomography, and that's designed to look at anatomical structures in the brain. The individual is placed in a donut-shaped [44] mechanism, and it takes axial tomographic pictures of the different sides of the brain.

MRI stands for magnetic resonance imaging, and this is kind of an expansion of what the CAT scan does, but it gives us more of a clear picture of soft tissue in the brain. With the advent of MRI's, they've picked up little tiny insignificant pimples in the brain that were never seen before and also gives you a more clear picture on different dimensions, and its a fascinating piece of equipment. That's also used in helping us localize and determine any kind of brain injury.

Q. All right. If we were to do any of these tests on Mr. Rompilla now, would that aid us in discovering or trying to find out what his mental capacity was back in January of 1988?

A. Again, that would be a very tough call to determine. First of all, I don't know anything would necessarily show up anatomically, all right; and because, you know, brain damage can be very diffuse and not necessarily visible to the naked eye, so it may or may not show up. Whether or not it's able to tell us anything has been there congenitally or instilled at any particular time in a lifespan, it's very difficult. It's only conjecture that a doctor would be able to determine that.

Q. Doctor, do you have an opinion to a reasonable [45] degree of psychological certainty as to who would have been best able to determine whether or not Mr. Rompilla had evidence of any of these mitigating factors at the time of the commission of this offense?

MR. WISEMAN: Objection.

MR. McINTYRE: You may answer.

THE WITNESS: Do I know who would have?

BY MR. McINTYRE:

Q. Yes.

A. Probably a trained professional who would be following his history and administered a battery of psychological tests every so many years and comparing them over time, along with any other evidence and history, would have a better opportunity to do that than someone trying to do it retroactive.

Q. That was a poorly worded question. Let me reduce your answer or give you a parameter of all the people you know who did examine Mr. Rompilla who would have been best able to make that call as to whether or not he evidenced any mitigating circumstances at the time of the commission of this offense?

MR. WISEMAN: Objection.

BY MR. McINTYRE:

Q. You may answer.

A. I think the two psychiatrists and [46] neuropsychiatrist.

Q. Dr. Gross, Dr. Cook, Dr. Sadoff?

A. That's correct.

Q. And you already talked about the tests, the psychological tests that Dr. Cook did.

A. Yes.

Q. Do you have an opinion as to whether or not they were adequate to determine whether or not Mr. Rompilla evidenced any of these mitigating circumstances at the time of the event?

A. Dr. Gerald Cook, let me say, is a very fine neuropsychologist. He's very thorough. He administered a select battery of tests at an initial screening. When he did not find any significant evidence on that testing, he discontinued any further testing out of the unnecessity.

Q. And is that appropriate?

A. Absolutely. There's no reason to subject someone to additional psychological tests when we have enough evidence to suggest there's nothing significant existing. Knowing Dr. Cook and his thoroughness, if there had been, he would have proceeded.

MR. McINTYRE: All right. I have no further questions. You can cross examine.

MR. WISEMAN: Let's take five minutes.

(Thereupon, a brief recess was taken.)

* * *

[47] CROSS EXAMINATION

BY MR. WISEMAN:

Q. Ready, Doctor?

A. Yes.

Q. Doctor, did you make any notes or memoranda or write any other or make any other writings other than the ones you provided to Mr. McIntyre?

A. No. The one you're referring to, May 1st, 1996?

Q. Right.

A. Yes, correct.

Q. No notes to yourself?

A. I made some notes.

Q. Can I see them, please?

A. Yes, sure. These are notes on Dr. Armstrong's report.

MR. McINTYRE: Let the record reflect the doctor handed him three pages.

THE WITNESS: And the underside of those three pages are scrap.

MR. McINTYRE: So it was all scrap paper; you only used one side?

THE WITNESS: Yes, recycling program.

BY MR. WISEMAN:

Q. Now, on these notes, these notes appear to be [48] summaries of the different testing that Dr. Armstrong administered?

A. Correct.

Q. And the summaries here appear to be things that contain material not in her report?

A. Correct.

Q. So they are your understanding of what the testing – what the testing involves?

A. Correct. Some of the tests that she administered I wasn't as fully familiar with as some of the other ones, so I made some notes on what I believed it was, what they measured, and then cross-checked them.

Q. So you essentially researched the tests she used?

A. I researched to check to make sure they were commensurate with my understanding and recollection of what those tests are used for.

Q. Okay. Now, may I see the letter that Mr. McIntyre sent you, please?

A. Sure.

Q. This is the April 8th, 1996 letter?

A. Correct.

MR. WISEMAN: It might make things easier, Mr. McIntyre, if we could just run off a copy of that, I just want to make a note or two.

BY MR. WISEMAN:

[49] Q. Doctor, I notice on your bookshelf a copy of Kaplan & Sadock, Comprehensive Textbook of Psychiatry?

A. Yes.

Q. Is that a book that you use in your work?

A. I've discussed it as a reference in some of the things I've written.

Q. It's a standard reference with the mental health profession?

A. Yeah, it's one of them.

Q. I also notice at least a smaller version of the DSM-IV?

A. That's a quick reference, yes.

Q. You also use the DSM in your work as a mental health professional?

A. Yes.

Q. And that's a standard reference as well?

A. Yes.

Q. Can you tell us what brain damage is exactly?

A. Good question. My understanding of brain damage is any unusual or abnormal condition of the brain that may have occurred during the course of development either indigenously or exdigenously.

Q. What do you mean?

A. What may have occurred from within due to natural physiological causes, or it may have occurred as a result of [50] some type of external blow or injury or exposure.

Q. Would it be fair, then, to say that the causes of brain damage could be trauma, one of the causes could be trauma?

A. Yes.

Q. A blow to the head?

A. True.

Q. And another cause could be disease?

A. That's correct.

Q. And earlier on, I think in discussing the MMPI with Mr. McIntyre, you indicated that brain damage – withdraw.

The MMPI is a personality test?

A. That's correct.

Q. And I think you said that a brain-damaged person might show up on MMPI, although it's not a neuropsychological test?

A. Yes.

Q. Just so the recrod [sic] is correct, MMPI is not a neuropsychological test; it's a personality test?

A. Yes, primarily used for that.

Q. Is it fair to say brain damage could have an impact on personality?

A Yes.

Q. And it can have an impact on function?

[51] A. That's true.

Q. And isn't it true that brain damage can affect one's cognition?

A. Yes.

Q. And one's reasoning?

A. Yes.

Q. And one's judgment?

A. Yes.

Q. And one's ability to predict future consequences?

A. Yes, that's correct.

Q. Future consequences of their actions?

A. Yes, correct.

Q. Isn't it true that brain damage can also impact on impulsivity?

A. Yes.

Q. And emotional ability?

A. Yes.

Q. And one's ability to control behavior?

A. That's also correct.

Q. Now, in your report, you indicate that you are attempting to give an objective opinion, quote, unquote?

A. Are you referring to a specific line?

Q. Oh, I think it's at the beginning of your report. If you want, I can find you the exact spot.

A. Right. Initial line, where he says, where I say, [52] This is in response to your letter dated April 8th, 1996, soliciting an objective opinion from me on the psychological and psychiatric evaluations of Mr. Ronald Rompilla.

Q. So the term objective opinion is one Mr. McIntyre used in his letter to you?

A. I believe so.

Q. You would agree that's something of an incongruity, objective opinion. An opinion, by its nature, is a subjective call?

A. Yes. Semantically, yes.

Q. While you may not agree with the opinions of the experts you've critiqued, you have no basis for saying that their opinion is any more objective than your opinion?

A. That's correct.

Q. Now, also, in the beginning of your report you mention, and I think you mentioned it in your testimony as well, that you did not see Mr. Rompilla?

A. That's correct.

Q. Did you think that was important to note in your report?

A. Yes.

Q. And why is that?

A. Well, because often times individuals may draw certain conclusions based on unclear information that would – that would suggest I did indeed evaluation him. I wanted [53] to make it very clear for the reader that I did not evaluate him, I did not meet him, nor did I have any access to the raw data on the reports.

Q. Now, in a neuropsychological setting, you would agree that face-to-face evaluation and interview of the patient is an essential component of it?

A. It's imperative, that's correct.

Q. So, for example, if someone has a large scar on their head and a concave area surrounding that scar, that might be something that a neuropsychologist or psychologist would want to inquire about?

A. Yes.

Q. And, obviously, if you don't see him, you can't inquire about it?

A. That's correct.

Q. And seeing a patient is also important in terms of interpreting testing as well, isn't that true?

A. That's correct.

Q. Now, correct me if. I'm wrong, but as I understand your view of Dr. Armstrong's report is that you do not disagree with her conclusion, that at the time she tested Mr. Rompilla he suffered from organic brain damage?

A. That's correct.

Q. Your quarrel with her, to the extent you have one – and correct me again if I'm wrong – relates to the [54] etiology of the impairments?

A. It relates to, in part, the etiology and also her ability to designate the time and chronology of the occurrence of the disorder, the damage.

Q. So you would agree that those two factors can be related?

A. Yes.

Q. Etiology as it relates to the timing of it?

A. Correct.

Q. Now, just so we're clear on the record, you state on page two of your report, the beginning of the third full paragraph, Dr. Armstrong appears to be accurate in her interpretations of the test results, which suggest that this gentleman does display evidence of a learning disability and brain damage as a potential result of alcohol abuse.

A. Correct.

Q. I believe on the top of page four you say, Dr. Armstrong's tests were, quote, unquote, valid and reliable?

A. Correct.

Q. And on page four in the last full paragraph, you say the neuropsychological tests used by Dr. Armstrong are quite accurate and are often used to help neuropsychiatrists and neurologists and sometimes neurosurgeons to determine localization of functioning with brain damaged patients.

A. Correct.

[55] Q. So, again, you had no quarrel with her conclusion about brain damage?

A. No, I do not.

Q. In Mr. McIntyre's letter to you, he asked you a question related to whether the doctors' opinions could have been infected in some way by some outside agenda. My question to you is, do you have any reason at all, based on your review of Dr. Armstrong's report, to think that her opinion is anything but a valid, reliable opinion as to the existence of brain damage?

A. That's correct.

Q. Now, let me ask you about a number of other neuropsychological tests. Are you familiar with the Shipley Institute of Living Scale?

A. Vaguely, yes.

Q. If I were to tell you that if a person were to score in a significantly impaired range on that test, would that be consistent with brain damage?

A. Yes.

Q. Are you aware of the Category Test?

A. Which one are you referring to?

Q. It's called the Category Test.

A. Is it part of the Halstead-Reitan?

Q. Yes.

A. I'm familiar with the Halstead-Reitan. I'm trying [56] to remember the Category Test. Why don't you go ahead.

Q. Well, my question is, if someone had significant impairments on that test, would that be consistent with brain damage?

A. Based on my knowledge of the validity of the Halstead-Reitan, the answer is correct, yes.

Q. If someone were to score, had significant impairments on the Wisconsin Card Sorting Test, would that be consistent with brain damage?

A. It could be. Again, let me state that usually we don't take any one subtest per se and draw a conclusion based off that. It's all sides considered equal so, you know, within that frame work, yes.

Q. Trails A and B, how about that test?

A. Yes.

Q. If I were to tell you that someone was impaired on a Trail A, would that be consistent with brain damage?

A. Yes.

Q. And how about significantly impaired with Trail B?

A. Yes.

Q. How about if someone were impaired under Laurie Christenson?

A. Spell it.

Q. That would be L-A-U-R-I-E – C-H-R-I-S-T-E-N-S-O-N.

[57] A. I'm not familiar with that test at all.

Q. How about the Rui-Ostreth, if someone were to be significantly impaired on that test, would that be consistent with brain damage?

A. Absolutely.

Q. Right-hand Indiana facia test (phonetic), if someone were significantly impaired on that, would that be consistent with brain damage?

A. Yes.

Q. A similar subtest of the WAIS-R, if someone were of the second percentile, would that be consistent with brain damage?

A. It would be, in and of itself.

Q. The WAIS-R is not a neuropsychological test, is it?

A. The WAIS-R is full range –

Q. By itself?

A. No, certain selective subtests are used. Similar tests measure categorical reasoning that could also be indicative of simply a mental disorder, like schizophrenia, that may not have an organic basis to it.

Q. Now, the testing I just went through with you comprised testing Dr. Crown testified to in these proceedings. Now, leaving aside the quarrel you may have with the format of his declaration, would you agree that [58] taking all of those tests I just ran through with the level of impairment that I just indicated, that that shows a profile of someone who has organic components?

A. If indeed those tests were administered, and they were, the scores are accurate, yes.

Q. You testified in the Martin Appel matter, is that correct?

A. Is that a matter of public record?

Q. Sure it is. You were in court, you were sworn.

A. Yes, I did.

Q. And prior to that, I think, if my recollection serves me, you filled out an affidavit, which was attached to the petition?

A. Yes.

Q. Verifying the facts in the petition were correct and accurate, correct?

A. Yes.

Q. And then you came to court and testified about it, isn't that correct?

A. That's right.

Q. Now, Dr. Crown's declaration was similarly attached to a pleading that was filed in court?

A. Uh-huh.

Q. You are you aware of that?

A. No.

[59] Q. Would you agree that there is a difference between a mental health report, a formal report, and an affidavit of a witness that's attached to a pleading for purposes of being told in court?

A. Particularly if they're labeled as such, yes.

Q. Is there anything in Dr. Crown's declaration that says that it's a report? Would you like a copy?

A. I think I have it here.

There's nothing here that states it as titled anything other than Section 1746 and 18 PA.C.S. at the top.

Q. I can assist. It says Declaration of Dr. Barry M. Crown pursuant to 28 U.S.C. Section 1746 –

A. You can see the copy I received doesn't have that at the top. I had no idea.

Q. Let me finish reading the caption for you, Declaration of Dr. Barry M. Crown pursuant to 28 U.S.C. Section 1746 and 18 PA.C.S. Section 4904. And it starts off with I, Dr. Barry M. Crown, do hereby declare and verify as follows.

A. Okay.

Q. That doesn't say it's a report?

A. I didn't have that information before, or it would have been more clear to me.

Q. Okay. Now, have you ever seen Dr. Crown's C.V.?

A. No.

[60] Q. Let me show a copy to you that's been previously marked. Why don't you take a look at it since you've never seen it.

A. Okay.

Q. Assuming that what's on Dr. Crown's C.V. is accurate, and I would state for the record that Mr. McIntyre stipulated that Dr. Crown is an expert in psychology and neuropsychology at his deposition, do you have any reason to think that Dr. Crown is anything but a bona fide neuropsychologist?

A. Not after looking at that, no.

Q. Now, the testing that I reviewed with you that Dr. Crown performed and testified to in his deposition, is that generally consistent with the profile you get from Dr. Armstrong's report?

A. Yes.

Q. All right. So they're both internally consistent in the sense they both show organicity?

A. Correct.

Q. So would it be fair to say, then, as we sit here today you don't have a quarrel with, assuming I've protrayed [sic] accurately what Dr. Crown testified to, that he, too, concluded accurately that Mr. Rompilla suffers from an organic impairment?

A. Yes.

[61] Q. And I take it, again, your quarrel would be in the case of the etiology and the timing of the onset of the –

A. That's correct, exactly.

Q. Now, you did have a couple of – I don't know whether to call them quarrels or quibbles, I guess you can testify – with Dr. Armstrong's report, the order in which

things were presented. For example, does that in any way diminish your opinion of the validity of her conclusions?

A. No, it was just my statement it was unusual. I guess this was the short form of her report. Typically neuropsychologist reports are very lengthy because they go in very great detail first and foremost with the individual's background, injuries and what led up to the event, why they're being evaluated. It was just unusually written.

Q. And you also have a comment in your report that you assume she is qualified, although she fails to state any of her credentials. You didn't state your credentials in your report, did you?

A. They're all over the letterhead, yes, I did.

Q. Oh, that's what you consider credentials, just the listing of –

A. Yes, whether they're a clinical psychologist or whether they're board certified, whether they're licensed. In the Commonwealth of Pennsylvania, you can work under the [62] auspices of an institution and call yourself a neuropsychologist even if you're not licensed and you're not board certified as long as you're under the institution. So typically, even when one is in part of an institution, they indicate that they are licensed as a psychologist in the Commonwealth, and they'll indicate if they're board certified, whether it be S.B.P.P. behind your name, whatever.

Q. Have you had a chance to review Dr. Armstrong's C.V.?

A. No.

Q. Why don't I show you that. It's been previously marked in these proceedings.

A. Okay.

Q. Do you have any view of Dr. Armstrong as anything other than a qualified, bona fide neuropsychologist?

A. No, she has good experience and training. I didn't see where she was board certified, though, which is unusual for a neuropsychologist. She's licensed in Ohio and Pennsylvania, and the licensing in all of the states of the United States are generic. In order for a person to be qualified in a subspecialty, the American Board of Professional Psychology was established in 1947 to indicate and certify by regular credentials check, evaluation and passing of a test.

[63] Q. So that would be board certified by the American Board of Professional Psychology?

A. As is the case with Dr. Crown.

Q. And Dr. Crown is a diplomate [sic] of the American Board of Professional Neuropsychology?

A. Yes.

Q. And I think his C.V. indicates he is the chair of the examination committee from '94 to 1997?

A. Uh-huh.

Q. So then the bottom line, just so I understand in regard to Dr. Armstrong, does your review of her curriculum vitae in any way cause you to question her conclusion?

A. No. I just think she should get board certified. It makes it easier when you testify in court; but, no, her education and credentials are excellent.

Q. Okay. Now, you have some experience, I take it, with abused children?

A. Yes.

Q. That's part of your practice?

A. Yes.

Q. And do you see adults who were abused as children?

A. Yes. I also see adults who are abusers for the Commonwealth of Pennsylvania.

Q. So that's something you're familiar with?

A. Yes.

[64] Q. And deal with routinely?

A. Yes.

Q. Would you agree that – and tell me if you would agree – people who are abused as children can show impulsivity?

A. Oh, yes, absolutely.

Q. And why is that?

A. Abuse usually has a multi-faceted effect on children. One of the effects it has on children, it tends to stimulate them, neurochemically often times as a result of – I'm speaking specifically of physical abuse, there may

be reaction that involves rage, recent, and that can be rechanneled into excess energy and express, acting out behaviors such as impulsivity.

Q. The impact that abuse has on a developing child is such that children have difficulty controlling their behavior, some do?

A. Correct.

Q. And that goes to impulsivity?

A. Yes.

Q. Would that also go to such children as being unpredictable?

A. It may.

Q. And, again, in the abuse dynamic, children don't – the people they look up to for security are often the [65] ones who are the abusers?

A. That's correct.

Q. And that can confuse a child?

A. Extremely.

Q. And that causes unpredictability?

A. That's right.

Q. Does it cause children to underachieve?

A. It may.

Q. Right. Of course, we're dealing abstractly, I assume?

A. Hypothetically.

Q. I'm asking, it may cause a child to underachieve?

A. That's correct.

Q. And that will be underachievement in terms of schooling?

A. It may affect academics, yes.

Q. It could affect a child's social relationships with others?

A. Yes, that's correct.

Q. They could be loners?

A. That's correct.

Q. They could be isolated from others?

A. That's correct.

Q. Which, I guess, is the same as saying they're loners, socially isolated?

[66] A. Yes.

Q. Off by themselves?

A. Yes.

Q. Does it cause them to perform erratically as well as to underachieve; in other words, sometimes they might achieve better than at other times with no apparent rhyme or reason to the differences?

A. That's possible, yes.

Q. Is delinquency from school something that abused children sometimes evidence?

A. Yes.

Q. What's a schizoid personality?

A. A schizoid personality is a disorder that falls under the category of what we call Access I Diagnosis of the DSM-IV, and it's a personality by which an individual is not psychotic but they're withdrawn. They become loners. They, for the most part, live in a nonpsychotic world. There's no break with reality, but they have difficulty with interpersonal relationships. They may not speak much, they have difficulty relating, you know, to withdrawal.

Q. Is that – some of what you just mentioned seems to be somewhat consistent with some of the other indicia of an abused child, the isolation, the inability to relate.

A. That, typically, is, the extreme version of an abused child, yes.

[67] Q. So an extremely abused child could have a schizoid personality?

A. Yes.

Q. Now, you went through the 1975 or '76 MMPI results with Mr. McIntyre on direct examination?

A. That's correct.

Q. Isn't it true, Doctor, that an accepted way of reading an MMPI is to look for the two high spikes, the two highest scores?

A. Only are you saying?

Q. I'm asking if it's an accepted way of reviewing the MMPI?

A. To look just at the two – well, no. I mean, many do it.

Q. How do you look at an MMPI?

A. Many do it. You have to remember, again, its all sides considered equal. You want to look at the two highest spikes. You want to look at the configuration of the validity scales and the other scales that are elevated and ones that are not elevated.

Q. Obviously, you want to look at validity scales; and in regard to Mr. Rompilla's 1975 test, you said they were valid scales?

A. That's correct.

Q. So its a valid test?

[68] A. That's correct.

Q. Once we've decided it's valid, would you agree that looking at the high spikes is something that would be an appropriate clinical approach to interpreting the MMPI?

A. Yes.

Q. And do you recall what the spikes are in Mr. Rompilla's?

A. Yes, the sociopathic deviance and schizophrenic scale was elevated.

Q. So that's a 4-8 spike?

A. Yes.

Q. Now, if someone comes to you with a 4-8 spike or you are called upon to interpret in a clinical setting a 4-8

spike, wouldn't you agree there are elements of a 4-8 personality that are consistent with that of an abused child?

A. Yes.

Q. In particular, are you familiar with the MMPI Handbook by Dahlstrom and Welsh, Volume Publication Copyright 1960, Sixth Printing 1986?

A. Yes.

Q. Now, I you want to read along or follow along, I should say, you can open to page 273.

MR. McINTYRE: Note for the record my objection.

MR. WISEMAN: Based on what?

[69] MR. McINTYRE: My understanding of the use of a learned treatise was to impeach, and I haven't heard anything insignificant. It seems like you want to reinforce something. If you want to get the doctor to say something and impeach him, that's proper.

MR. WISEMAN: I see it more as making clear for the record what we're talking about since we are dealing with matters of professional expertise.

THE WITNESS: All right.

BY MR. WISEMAN:

Q. The portion I asked you to review is the clinical configuration section of Dahlstrom, which deals with the two high spikes, and I've asked you to look in particular at the 4-8 section, and it says that persons with this profile, the 4-8, are described frequently as odd, peculiar or queer.

They are unpredictable, impulsive, nonconforming and the term schizoid personality frequently applies to them. Their education and occupational histories are characterized by underachievement, marginal adjustment and uneven performance. Nomadism, social isolation or underworld membership is often present. Delinquency is closely associated with the 4-8 profile.

I think you would agree, as I said earlier, those are also consistent with the profile of an abused child?

A. That's correct.

[70] Q. Now, if someone, let's say a child came to you and took an MMPI, if a child came to your office today and you scored their MMPI and they had a 4-8 spike, that would cause you to look further?

A. Yes.

Q. You would want to know why they're speaking in a peculiar way?

A. Yes.

Q. And you would look into if there's abuse?

A. Family dynamics, abuse, yes.

Q. I think we also talked about brain damage. One of the things you said that happens with abused children is that they are stimulated neurochemically?

A. Yes.

Q. That's an organic manifestation or organic consequence of abuse?

A. Yes.

Q. And you agree abused children often demonstrate central nervous system deficits?

A. Yes.

Q. So would it be fair to say, then, if you saw a child who met this abusive profile, you would also want to be on the lookout for organic problems?

A. I would want to rule them out, yes.

Q. Or rule them in, right?

[71] A. Correct.

Q. Just so I understand where we're at, then, if child comes in, takes a MMPI, scores a 4-8, as a clinician you need to look at abuse and you need to look at organicity?

A. This is assuming, by the way, that in your hypothetical scheme that the child is old enough to take the MMPI. Children usually don't take it. We have adolescence tests.

MR. McINTYRE: Note my objection. I don't know how the child taking an MMPI has any relevance to this test. Mr. Rompilla would have been 28.

MR. WISEMAN: We'll connect it up.

MR. McINTYRE: All right.

BY MR. WISEMAN:

Q. All right. Just so I have the answer clearly then, as a clinician you would look to abuse, you look to organicity?

A. Yes.

Q. You would look to organicity. Would you look to organicity as evidence of abuse, or would you look to organicity as a potential cause of abuse? In other words, sometimes organic children act out sometimes in certain ways that causes them to be the targets of abuse?

A. My inclination would be to look at it either way, [72] but I would probably be more biased to looking at whether or not abuse caused any of this.

Q. That abuse caused the organicity?

A. Yes.

Q. Trauma to the head, for example?

A. That's correct, assuming we're talking about physical abuse.

Q. That's what we're talking about. Actually, would any of these things we just discussed apply to someone who's not only physically abused but also psychologically abused in the sense they live in a dysfunctional family?

A. Yes.

Q. So if your parents are always calling you a dummy and showing you no affection, that would add to the profile as we've discussed?

A. That's correct.

Q. Now, in addition to the 4-8 spike that Mr. Rompilla showed on that test, the MMPI Test in 1975, he also spiked high on paranoia and hypochondriacal. He scored 82 on each of those.

A. Correct.

Q. And he was also spiked abnormally high on neurotic at 76, and he scored a 73 on the neurotic obsessive compulsive scale, is that correct?

A. Yes.

[73] Q. So these are all abnormally high scores?

A. Yes.

Q. That does not – withdraw it. That certainly doesn't diminish the profile of MMPI as of a healthy person?

A. No, that's reflective of the fact that the two, 4 and 8's, were so high, it inflated all the other scales as well.

Q. So that's a profile of a disturbed person?

A. Yes, you bet.

Q. Now, you were discussing Dr. Cook's work on this case; and in Mr. McIntyre's letter to you, he states on page two, that's Mr. McIntyre, that the tests which he, Dr. Cook, performed were the MMPI, the Rorschach, the Sentence Incomplete and the Wechsler IQ.

A. He spelled Wechsler incorrectly.

Q. Mr. McIntyre, yes. And Rorschach?

A. Right.

Q. And Mr. McIntyre also says to you in the second or the first full paragraph on page two, Dr. Cook did testify at his deposition that if he had the school records, he would have done additional neuropsychological testing?

A. Yes, that's correct.

Q. Now, did you interpret that statement from Mr. McIntyre in his letter to mean that Dr. Cook had performed neuropsychological testing?

[74] A. No. I interpreted it that he was not – he did not decide upon the test that he would administer without reviewing all of the information, that he was assuming that he had all the information, that's why he chose those tests. If he had the additional information, the school records, he may have gone on and given some other tests. That's how I interpreted it.

Q. So your understanding is Dr. Cook did not perform any neuropsychological testing in 1988 on Mr. Rompilla?

A. That's correct.

Q. And as we discussed earlier, the WAIS-R is not a neuropsychological test by itself?

A. That's correct, but let me say this, too, to expand that response, that the full scale Wechsler Adult Intelligence Scale and the Rorschach, which is also very helpful in suggesting any signs of organic brain damage, are sufficient at times to indicate whether or not there was an existence of any type of a neurologic dysfunctioning that would then induce one to give additional measurement.

Q. So what you're saying then is that although not perfect, a full WAIS-R can serve as sufficient testing, neuropsychological testing?

A. As well as the Rorschach, yes.

Q. Now, based on that you, your view of Dr. Cook's testing in '88 is that if he had seen anything unusual in

[75] the full WAIS-R, that would have caused him to do additional neuropsychological testing?

A. Without a doubt.

Q. Now, would your opinion change if I told you Dr. Cook did not do anything approaching the full WAIS-R, in fact, did three subscales?

A. Yes.

Q. And if he did just three subscales, you'd agree that is not adequate or not even begins to be an adequate neuropsychological screen mechanism?

A. It depends on what subscales he used. Could you tell me what specifically they were?

A. Well, I can read to you the paragraph from his deposition, page six, in which he says what tests he gave.

A. That would help.

Q. He said I would have given an MMPI, I would have given him an Incomplete Sentence, Rorschach Ink Block Technique and any of the two or three subtests of the Verbal Subscale of the Wechsler Intelligence, Adult Intelligence, WAIS Revised, WAIS-R. Now, you'd agree – well, withdraw it.

Dr. Cook testified also he did not consider that to be a neuropsychological screening?

A. And I agree.

Q. So we are in agreement, then, that Dr. Cook did no [76] neuropsychological screening in 1988?

A. That's correct.

Q. Now, we've gone over, you've gone over with Mr. McIntyre the various school records of Mr. Rompilla?

A. That's correct.

Q. And just give me a moment to find my file. Let's take them one at a time. Let's first talk about a test of 9/54, September 1954. It says S.R.A., and it has an IQ of 60. Are you familiar with the S.R.A.? I'm wondering if it could be the S.A.R.

A. I think it was transposed. I think it was the Stanford Achievement Record.

Q. So he scored in a – well, did he score in a retarded range on that achievement test?

A. Well, it says IQ 6.

Q. That's a typo. I think the original said 60. Assume it says 60.

A. Assuming it said 60, he would be in the mildly mentally retarded range.

Q. Now, in 1954 Mr. Rompilla, who was born in 1948, would have been roughly six years old?

A. Correct.

Q. So at six years old, he's scoring in the – somewhere in the retarded range. Let's look at the next test, which is April of '57. He takes the verbal portion of [77] the WISC, and he scores a 75?

A. Yes.

Q. And that's what, in the borderline or retarded?

A. That's in the borderline range.

Q. But that's only half a test; that's not the performance?

A. Yes.

Q. And verbal without a performance is really not a completely accurate picture?

A. Right. Although, I have to say, within the verbal subtests, the one test that is probably the most indicative of IQ is the vocabulary subscale, so it's not far off; but you're right, it's not complete.

Q. All right. So that would have been at approximately – I'm really pushing my arithemetic [sic] – approximately age nine?

A. Yes.

Q. Now, two years later at age eleven he scored a 64 full scale on the WISC, and that is clearly within the retarded range, is that right?

A. That's right. Mildly mentally retarded.

Q. And if you turn the page, in December of '61 when he would have been approximately thirteen years old, he scored in the range of retardation again with a full scale of 69, is that correct?

[78] A. That's correct.

Q. So that you have, in effect, someone who between the ages of six and thirteen is scoring consistently in the retarded range, and the best he did was the 75, which puts him in the borderline on an incomplete test?

A. Right.

Q. Now, let's make believe, again – since we're dealing with children we can make believe – that a child comes into your office, is fifteen years old, and you see these scores. As a clinician, are you going to look for organicity?

A. I would be concerned about it, yes.

Q. As a clinician, would you look for abuse?

A. Yes.

Q. And the reason you would look for abuse, I think as we discussed earlier, abused children often underachieve in school?

A. Yes. I would also look for depression because scores – abused kids can be depressed as well.

Q. Now, a mentally retarded kid or kids in the borderline of mental retardation are often placed in special education classes?

A. Today, yes.

Q. And would you agree, then, that placement in special ed is an additional indicator or red flag, if you [79] will, that someone might have a cognitive impairment?

A. Yes, correct.

Q. Also, placement in special ed could also be evidence or an indicator of an abusive home life?

A. Correct.

Q. Now, if you look at the first page of the school records, you'll see starting in 1957 – well, if you look at the column that says grades, it says K, 1, 2, and 3, and

starting in '57, you see SP, SP, SP. That's an indicator of special education, isn't it?

A. Yes.

Q. So Mr. Rompilla, then, starting at the age of nine years old would be in special education class?

A. Yes, and that would be commensurate based on his scores in 1957.

Q. So everything you're seeing on this school record is consistent with either abuse, organicity, or both?

A. Well, we were talking about hypotheticals, now we just switched to reality. What's happening here is that they're recognizing that based on his achieved scores and his grade performance he was placed in special ed. I don't know if anybody drew the connection of organicity; and, again, I would have to see all of the subscales in order to look at the scatter and see what that determines

Q. Fair enough. If you were to view this record, [80] this school record by itself as a clinician, would you want to rule out organicity as a cause for the underachievement, for the retardation scores and for the placement in special ed?

A. I definitely would.

Q. Would you certainly want to rule out an abusive dynamic at home?

A. Absolutely.

Q. No doubt about that?

A. No doubt about that.

Q. Now, would it surprise you if I told you that Dr. Cook testified that if he had these school records when he was evaluating Mr. Rompilla – well, withdraw.

Dr. Cook testified he did not have these school records when he evaluated Mr. Rompilla in 1988?

A. Correct.

Q. Would it surprise you if I told you that he also testified that if he had the school records, he would have done neuropsychological screening, which he did not do in 1988?

A. It wouldn't surprise me.

Q. It would be expected?

A. Sure.

Q. Now, Dr. Cook also testified that the neuropsychological screening he would have done would have [81] consisted of Trails A and B?

A. Yes.

Q. That would surprise you?

A. No.

Q. It would not surprise you?

A. No.

Q. That would be an appropriate screening mechanism?

A. It would be one, yes.

Q. And I think he also testified that he would have used the tapping test of the Halstead-Reitan?

A. The oscillating finger, yes.

Q. And that would also be an appropriate screening mechanism?

A. Yes.

Q. That seems reasonable to you as a clinician?

A. So far.

Q. Now, getting back to your essential quarrel with the two defense experts regarding the identification of the commencement of the organic impairment and the etiology of it, we discussed earlier that the organicity can be caused by trauma to the head?

A. Can be, yes.

Q. And it could also be caused by disease?

A. Yes.

Q. So you could be born with an organic impairment?

[82] A. That's correct.

Q. One can develop one during their life time?

A. That's correct.

Q. And that could be either by trauma or disease?

A. That's correct.

Q. Now, in trying to determine the reasonableness of Dr. Armstrong and Dr. Crown's conclusion that Mr. Rompilla's deficits are longstanding and going back to childhood, wouldn't you agree that the school records are consistent with the – with their opinions that the organic impairment existed in childhood?

A. Well, I can see how one would want to draw that conclusion. The argument that I have is the cocksuredness that they state in their reports. I beg to differ with that because it's virtually impossible to determine that.

Q. We'll address that. My question, though, was it consistent with longstanding organicity that existed in childhood, not is it certain, is it consistent?

A. Is it consistent, yes.

Q. Okay. Now, in your testimony on direct examination you said something to the effect – I'm not sure this is an exact quote – that you didn't see a hint that either Dr. Armstrong or Dr. Crown knew anything about Mr. Rompilla from 1988 until the date of their testing?

A. That's in the report?

[83] Q. No, that's what you testified to, that you didn't see a hint in your reports or in their statements that they knew anything about Mr. Rompilla from 1988 until 1996?

A. Yes, that's correct.

Q. And that, I take it, goes to your quarrel with this certainty with which they stated their opinions?

A. That's correct.

Q. Conversely, if they had information from Mr. Rompilla about what went on from 1988 to 1995 or '96 when the testing was done, they would be in a better position to identify the etiology and the duration of the organic impairment?

A. Yes.

MR. WISEMAN: I hate to do this. I need to take a break.

MR. McINTYRE: Sure.

(Thereupon, a brief recess was taken.)

* * *

MR. WISEMAN:

Q. Now, Doctor, looking at the period of time from 1988 until, let's call it the period of testing as Dr. Crown did his testing in late 1995 and Dr. Armstrong did in early '96, from '88 until the time of the modern day testing, would you be interested in knowing if Mr. Rompilla suffered a head trauma in prison?

[84] A. What I would be interested in knowing is any records held by the infirmary, the nurse, whether there are any physical examinations by a physician, a psychologist, a neurologist during that period of time. I would be interested in knowing some of the prison records, as far as his behavior, any altercations that occurred; but, again, any injury wouldn't have been reported necessarily to the infirmary.

Q. You'd want to see the medical records?

A. I would also want to see if there was any indication, by virtue of the prison records, that he was using any substance at that time, homemade or whether it was transferred in or whatever.

Q. You're aware, or are you aware that people on death row in this state are kept in single cells?

A. Yes.

Q. And they're kept in isolation; they're not in population?

A. Yes.

Q. They're locked in all the time, you're aware of that?

A. Yes.

Q. And they're kept, obviously, under tighter security than regular inmates are?

A. Yes.

[85] Q. Or noncapital inmates, I should say?

A. Yes.

Q. And you would agree that that type of close confinement greatly diminishes or eliminates completely their ability to engage in various substance abuse, not saying it's impossible, mind you, but it obviously would reduce their chances?

MR. McINTYRE: I'm going to object to that. I don't know if he's qualified to render an opinion on that, You should have somebody from the prison here.

THE WITNESS: I've worked in prisons, I've been involved in them, and I think I know if you take lemonade and store it and fill it with sugar, over time you have something that ferments. You could make just about anything. It minimizes it, yes, it reduces it, yes.

BY MR. WISEMAN:

Q. And as far as using other types of substances, illegal substances, obviously, to the extent people don't

have contact, prisoners don't have contact with other prisoners, their chances of getting such substances are also reduced over a general population?

A. Yes.

Q. It's a matter of common sense?

A. Yes. It would have to be by the guards, who are the people that bring them in most of the time anyway.

[86] Q. So what you'd want to see, then, to try to lock in this period of time, is you'd want to see medical records, and you'd want to see some evidence about whether or not the person had been bringing or abusing drugs during the period of time they were in jail?

A. Yeah. I'd even want to know whether some lonely guard on a Saturday night noticed Rompilla was banging his head against the floor or against the wall for some unknown reason. I'd want to know anything that was peculiar or unusual.

Q. And, again, banging the head against the wall could develop to a notation on an infirmary record?

A. Yes, or Damage to Prison report.

Q. Why don't we look at Mr. Rompilla's complete Department of Corrections record. Perhaps we can mark it over the prior exhibit tab, and I'll state for the record what this is. This is the entire ambulatory medical record, including dispensary card provided to us by the Department of Corrections for Mr. Rompilla, and it is in the same order that it was given to us, with the exception that the top sheet was placed on top by me on purpose, and we'll discuss that in a moment.

MR. McINTYRE: Mike, I have to place an objection. Obviously, you can use it today, but at some point it has to be authenticated. I'm not accusing you of anything. We [87] need some custodian record at some point.

MR. WISEMAN: That's fine.

BY MR. WISEMAN:

Q. Now, the very top sheet you'll note is dated 1/18/88, and it has a section about halfway down the page, it says other pertinent information, and it says scars, and you see it says above left eye?

A. Yes.

Q. So it appears, although you can't tell from that entry what the extent of the scarring was, it appears he has – when he entered the prison in November of 1988 Mr. Rompilla had some type of marking above his left eye?

A. Yes, and this was where? What facility was he at?

Q. This is when he was received by the Pennsylvania Department of Corrections. I would state for your benefit, Doctor, that he was sentenced to death, I believe, on November the 2nd of '88. So this is approximately a week after he was sentenced, he was sent over to the Pennsylvania Department of Corrections, and we see the notation.

A. So between the 2nd and – when he was at the facility?

Q. Yes.

MR. McINTYRE: And between his arrest and the 8th, he was housed at the local facility.

THE WITNESS: Okay.

[88] MR. McINTYRE: I think he was arrested in January of '88.

BY MR. WISEMAN:

Q. Now, if you turn a few pages in, you'll see the beginning of entries, and this is roughly in verse, in chronological order with the most recent ambulatory entries first. I'll also state to the extent it will shed some light on your review of them that Mr. Rompilla's death warrant was signed in approximately June of '95. He was placed in what's known as Phase II custody, and he is seen on a daily basis by health care providers; and so the vast majority of this record covers a three month period, June, July, August of 1995.

So with that preface, what I'd like to do is turn to the back and look at the older records first. Basically, what I'd like you to do is take as much as time as you like, why don't you go through this record and show me any indication of any trauma to the head.

MR. McINTYRE: You know, I'm objecting to this. This isn't the time to do this. This doctor doesn't have a week to sit here and look at records that are approximately half an inch thick here. If you wanted him to do that, you should have sent these up ahead of time. It's not for this witness to do that, and I'm objecting to it. I have to think about this, but I may direct him not to answer it.

[89] You can do this with anybody. To do this with Dr. Dattilio and his time, it doesn't make any sense to me.

MR. WISEMAN: Let me state for the record, until I got your report at noon on Friday, I had no idea

that your expert was going to be speculating about head injuries that may have occurred in the Department of Corrections in the previous six years, and so I would have had no reason to send these to him. I'll tell you what I'm willing to do. I will ask the hypothetical question to the doctor, assuming there's no --

MR. McINTYRE: It's not fair to have him sit here and try to find something in this time.

MR. WISEMAN: And before we rest on the record, I'd like to have the district attorney's position as to whether the district attorney finds any indication of head injury.

MR. McINTYRE: I'm not going to do it today.

MR. WISEMAN: Rest on the record before Judge Wallitsch.

MR. McINTYRE: You're going to have to authenticate them, introduce them.

BY MR. WISEMAN:

Q. Doctor, assume, then, that in this stack of records which cover the entirety of Mr. Rompilla's involvement with the medical authorities, all the various [90] prisons he's been in from November 8th of '88 until 11/95 that there is no evidence at all, not a hint, not a clue, not a whisper of any trauma to the head. Would that satisfy you to some degree that Dr. Crown and Dr. Armstrong's conclusions dating the onset of the organicity and the etiology of it is accurate?

A. It would reduce some of my skepticism. I would still have, you know, other concerns.

Q. Okay.

(Defendant Dattilio Exhibit No. 1, Ambulatory Reports, was marked for identification.)

BY MR. WISEMAN:

Q. You said you would still remain somewhat skeptical. What else would reduce your skepticism?

A. This doesn't count for the county time he spent in prison.

Q. Oh, I see, from the time of his arrest until –

A. That's correct, and whether or not there was, which there would have been greater likelihood of substance abuse in county prison, which is always the case as opposed to a state penitentiary.

Q. So we haven't ruled out the possibility that he may have suffered some trauma post-dating the crime?

A. Correct.

Q. Is there anything else that causes you to remain [91] skeptical in regard to trauma?

A. No.

Q. Now, with regard to alcohol or substance abuse during this time, at least in the Department of Corrections, again, your concern is that we don't know, I think as you said, there is no hint that Dr. Armstrong or Dr. Crown had any information post-dating 1988?

A. Correct.

Q. By the way, if I told you that Dr. Crown reviewed the D.O.C. medical records before his deposition testimony,

would that cause you to still yet have skepticism about his conclusion; in other words, he reviewed these materials in your hand?

A. Before his deposition?

Q. Yes.

A. And this was after he rendered a report?

Q. After he made a statement – actually, no, I'm not sure. I'm not sure. I don't want to testify. Let me read to you his deposition, and we'll let his own words speak for themselves.

Okay. On page six, the question is asked, I want to talk for awhile about what went into your evaluation and the records and things, the records you reviewed and the things you did. What records did you look at, Doctor? Answer, I reviewed a fairly large stack that includes [92] Mr. Rompilla's educational records, which related to his early schooling. I reviewed his packet of materials, including medical materials from the Commonwealth of Pennsylvania, Bureau of Corrections. I reviewed other medical records relating to his early leave. I reviewed various reports in that packet, the consulting psychiatrist in the facility. Would that be Kate Erwin? Answer, yes.

Later on page seven the question is asked, The Department of Corrections indicated you said there were some medical records in there. Were there any other mental health records? By other records, I am referring to mental health records. That was his answer.

It appears from his testimony that he reviewed medical and mental health records from the Department of Corrections?

A. That's correct.

Q. Now, getting back to the alcohol and substance abuse in prison, let me refer you, if I could, to Dr. Armstrong's report.

A. Are we finished with these?

Q. Yeah, for now.

Okay. On page three of her report, background information, Dr. Armstrong says then at about 1965 at the age of seventeen, he began drinking Thunderbird wine until he passed out about three times a week. Then he binge drank [93] whenever he went out. Even in prison he made homemade wine. He last drank in 1988.

So it would appear that Dr. Armstrong did, in fact, question Mr. Rompilla about his drinking both inside of prison and outside of prison. That's in her report.

A. That's true.

Q. And, in fact, she has it down that he even drank wine in prison before he was a capital prisoner, i.e., before 1988?

A. True.

Q. So it's fair to say that she was not completely in the dark in regards to the question of his drinking in prison?

A. Well, yeah, as biased as it may be coming from a defendant, yes.

Q. Now, does that bit of information make you any less skeptical about the issue that we've been discussing?

A. What we just went over?

Q. Yes.

A. A little bit, yes. Once again, if I might state for the record that this information is coming from Mr. Rompilla who, you know, I don't know – we'd have to question the validity of it.

Q. Would you agree that in a forensic setting relying on the self report of a patient/defendant is not the wisest [94] course?

A. No, I would agree it's not the wisest course. Whether or not Mr. Rompilla takes the wisest course, though, is another question.

Q. I'm talking about from a clinician's point of view?

A. Yes.

Q. When you evaluate a forensic patient, you don't want to just rely on what they tell you?

A. Absolutely.

Q. You want to get collateral sources?

A. Absolutely.

Q. And that would include family?

A. (The witness nods his head.)

Q. You have to speak?

A. Yes. I'm sorry.

Q. That would include – you said just the family?

A. Yes.

Q. That would include records, school records?

A. School records, prison records.

Q. Records about prior incarcerations?

A. Correct.

Q. Now, would your skepticism diminish further if there were other evidence in the record reviewed by Dr. Armstrong and Dr. Crown which also supported the [95] position that Mr. Rompilla was not drinking in prison in 1988 onward?

A. Yes.

Q. All right. Previously marked and part of the petition in this case is the – is two reports from Dr. Kate Erwin, one of which is dated July 3rd, 1995, Access [sic] I Diagnosis of alcohol dependence, in remission due to incarceration.

MR. McINTYRE: This is objected to.

MR. WISEMAN: On what basis?

MR. McINTYRE: It's a hearsay report.

MR. WISEMAN: You missed that part, Michael. The judge allowed it.

MR. McINTYRE: All right.

MR. WISEMAN: The judge let this in so we didn't have to drag Dr. Erwin in all the way from Pittsburgh.

MR. McINTYRE: I realize there are days I wasn't there.

MR. WISEMAN: The records will show that before testimony given in this case, Judge Wallitsch specifically allowed this report in in consideration of quashing our subpoena for Dr. Erwin.

MR. McINTYRE: And I don't know if there's testimony that was relied upon by either Crown or Armstrong. I don't remember that, but I'll object on that basis.

[96] MR. WISEMAN: All right.

BY MR. WISEMAN:

Q. Now, would you agree that that Access [sic] I Diagnosis tends to show that Mr. Rompilla is not drinking from 1988 onward?

A. Yes.

Q. And does that further reduce your skepticism?

A. To some degree, that's correct.

Q. And would it further reduce your skepticism if I were to tell you that Dr. Crown and Dr. Armstrong had the mental health records, of which this report was a part, when they made their opinions about Mr. Rompilla's organicity?

A. That would reduce it, yes.

Q. Now, Mr. McIntyre asked you a number of questions about different individual pieces of evidence in this case and asked you if by themselves they would, in your view, constitute any of the two mental health mitigators in Pennsylvania?

A. Yes.

Q. And I think your answer was not by themselves?

A. Right.

Q. We have gone over the effect on personality of both abuse and organicity, correct?

A. Yes.

Q. Hypothetically speaking, if you have a severely [97] abused child who grows into adulthood and have that same child who has an organic defect of the type that Mr. Rompilla had, wouldn't you agree that that adult could act impulsively?

A. Yes, could indeed.

Q. And that adult would have basically all the personality problems conceivably that we discussed at the beginning related to lack of control of behavior?

A. That adult could.

Q. Inability to control, to predict future consequences?

A. Correct.

Q. Emotional ability?

A. Yes.

Q. All those tell-tale signs of an organically impaired, abused person?

A. Yes.

Q. So my general question to you, then, at this point is given all that you now see about Mr. Rompilla, the school records showing retardation, the school records

consistent with abuse, the consistent pattern over years of not achieving well, the MMPI, which you said is consistent with abuse and organicity, taking all that together, wouldn't you agree that Mr. Rompilla, from these records – let me rephrase that.

[98] Given all the things we just talked about, wouldn't you agree that there's some possibility that Mr. Rompilla's behavior at the time of the commission of the offense was governed by one of the two mental health mitigators that apply to it?

MR. McINTYRE: Objection to the form of the question, some possibility.

MR. WISEMAN: We'll see where we go. You can answer.

THE WITNESS: There's some possibility. It lends credence to the idea.

BY MR. WISEMAN:

Q. It's not outlandish?

A. No.

Q. Okay.

A. But at the same time it's not accurate, either.

Q. Okay. Well, fair enough.

Now, as a clinician in 1988 evaluating Mr. Rompilla, you got the schooling records, you got MMPI, you've got all the information that we've gone through today, what do you do?

A. What I would have done, I would have given him as extensive as a battery of tests that I could.

Q. And if that battery of tests showed neuropsychological deficits of the variety and the type [99] identified by Dr. Armstrong and by Dr. Crown, would you agree they would be an emotional disturbance in accordance – well, let me withdraw that and ask it a different way. Just bear with me a moment.

Would you agree that the organicity identified by Dr. Armstrong and by Dr. Cook or Dr. Crown constitues extreme emotional disturbance?

A. Yes.

Q. And given what we've discussed in terms of its impact on personality, that such an extreme emotional disturbance could, at the time of the offense, have prevented Mr. Rompilla from appreciating the criminality of his conduct or to conform his conduct to the requirements of the law?

A. It may have.

Q. And the point is, Doctor, that in 1988, if you were reviewing this stuff, you would have wanted to do additional work to answer that question?

A. Yes.

Q. Okay. By the way, Dr. Cook and Dr. Sadoff both testified in their depositions that they agree with you – well, withdraw that.

MR. McINTYRE: Is that a question?

MR. WISEMAN: That's a statement.

THE WITNESS: They agree with me?

[100] MR. WISEMAN: Yes.

THE WITNESS: Having not known that I said it, though.

BY MR. WISEMAN:

Q. I'm saying, they said something consistent with what you just said.

A. Okay.

Q. Now, in your report one of the, as we discussed, one of the quarrels you have with Dr. Armstrong's report is that on page two in the third full paragraph, you say she rules out the fact that it does not fulfill the criteria for Korsakoff 's dementia. However, it is also not necessarily conclusive that Mr. Rompilla's deficiencies are definitely alcohol related?

A. Correct.

Q. Now, Dr. Armstrong didn't say that all of his deficits or Mr. Rompilla's deficits were alcohol related?

A. No, she implied.

Q. Did she? Let's look at her report.

A. The tenor of her report seems to imply that his history of heavy alcohol abuse was a substantial contributor to.

A. If you look on page 4 of her report.

Q. All right. Let me direct you to the page that I want you to look at, if that's all right.

[101] A. Sure.

Q. On page one, the beginning of the report, The deficits, obviously talking about the organic deficits, which are consistent with the chronic effects of alcohol are visuospatial deficit, conceptual deficits, I'll skip a phrase there, short term memory and learning, normal rates of forgetting, impaired visual scanning and attention. While this can account for a number of his deficits, there are other problems which go beyond that expected in cases of chronic effects of alcohol. It should also be noted that he does not demonstrate the neurocognitive pattern of Korsakoff's dementia.

In the next paragraph she goes on to say, The deficits which go beyond the effects of alcohol include defective manual praxis, problems in word recognition and in language structure and writing. She then goes through the family history. She concludes that paragraph by saying, if learning disability can be documented in childhood records, then several of his neurocognitive deficits, including reasoning and memory impairments, may be a product of developmental learning disability primarily.

Okay. Isn't it true, then, in her report she also takes into account things that pre-date the reporting of alcohol abuse by Mr. Rompilla?

A. That's correct.

[102]Q. She's saying, in effect, he may have had organicity from the time he was born?

A. He may have.

Q. That's what she was saying?

A. Yes.

Q. And she's saying in that report that if you have any records indicating learning disability as a child, that would support her conclusion that the organicity is developmental and goes back to childhood?

A. May have been developmental, yes.

Q. Okay. Now, you would agree that the school records we've gone through fit that bill, don't they?

A. As far as I can see, yes.

Q. And the schooling records are, therefore, consistent with developmental early childhood organicity?

A. Would you repeat that, please?

(Thereupon, the court stenographer reads back the last question.)

THE WITNESS: Well, the school records are indicative of early – of developmental problems and learning disability. Whether or not it's got an organic basis is still questionable. We don't know.

BY MR. WISEMAN:

Q. But it's consistent with it? It's not inconsistent?

[103] A. It appears consistent, yes.

Q. And, in fact, when you look over the history of Mr. Rompilla, what is known about him and what is not known about him, wouldn't you agree that this is more likely that his organic deficits date the childhood than that they date something that happened to him in prison from 1988?

MR. McINTYRE: Object to the form.

THE WITNESS: I can't draw that conclusion. I can't –

BY MR. WISEMAN:

Q. You can't draw a more likely than not conclusion?

A. No.

Q. Okay.

A. Again, we're dealing with very patchy information here. There's a lot of variables involved. That's a big leap to make.

Q. Right.

A. It gives us a direction. Understandably, I can understand why one would be encouraged to investigate, but by no means is that sufficient information to make that profound conclusion as far as I'm concerned.

Q. Suffice it to say in 1988 if you were examining Mr. Rompilla for a capital case, you would have explored the things we just discussed?

A. Yes, absolutely.

[104] Q. Now, one of your quarrels with dating the etiology has to do with the issue of head trauma being reported by Mr. Rompilla to Dr. Armstrong and Dr. Crown?

A. Yes.

Q. And I think, to put it in a nutshell, tell me if this is accurate, essentially what you're saying is he didn't tell Dr. Gross about it?

A. Right.

Q. Is Dr. Gross – in your report you say you doubt Dr. Gross would have quote, unquote, lied about such a statement?

A. Right.

Q. You would agree that there's other things that could go on in a forensic interview that is short of a lie that could explain inaccuracy in a report?

A. Yes.

Q. For example, a cognitively impaired person may not have been a good historian of their life, that's one explanation?

A. Yes.

Q. A forensic examiner might not be as careful on a particular occasion to ask the questions that need to be asked to elicit the information?

A. Possibly.

Q. And as we discussed earlier, relying on self [105] reporting in a forensic setting is not a good idea to begin with?

A. Yes.

Q. You've got to get collateral information?

A. Correct.

Q. And, in fact, we know that there are certain things in Dr. Gross' report which simply aren't true, they're inaccurate, right, such as his statement that Mr. Rompilla was never hospitalized? We know that's not true.

He was hospitalized on at least one occasion when he was two years old.

MR. McINTYRE: I'm going to object to that. What's the point of this? Dr. Gross gave the information on the report that he got from Mr. Rompilla. If it was inaccurate, it was Mr. Rompilla giving him inaccuracies. What's the point?

MR. WISEMAN: That is the point.

BY MR. WISEMAN:

Q. Would you agree that Dr. Gross, who relied solely on Mr. Rompilla, and he admitted that in his deposition, he had no collateral information, his report has an inaccuracy regarding hospitalization?

A. Yes.

Q. We've seen the records. We know, in fact, he was hospitalized?

[106] A. Yes.

MR. McINTYRE: You're referring to the 1950 hospitalization when Rompilla was one and a half years old?

MR. WISEMAN: Exactly.

BY MR. WISEMAN:

Q. Now, in your practice with families and abuse, you have been exposed to the dynamic of denial; people abuse, people who are abused will often deny that they were abused?

A. Yes.

Q. And that's true in children, right?

A. That's correct.

Q. That's true in adults who are abused as children?

A. Yes.

Q. And it's also true of adults who were abusers?

A. Yes.

Q. And it's also true of siblings who witness abuse?

A. Yes.

Q. And that's something as a clinician you're on guard for when you're evaluating a potential abuse situation?

A. Yes.

Q. So you don't just sit the kid down and say, were you abused?

A. Yes.

Q. You do more than that?

[107] A. Yes.

Q. You subjectively and gently probe?

A. That's correct.

Q. And when you're examining an adult who you think may have been the victim of abuse as a child, you similarly don't just ask a blunt, open-ended question, were you abused type questions?

A. Yes.

Q. Because it's embarrassing for the victim of abuse to talk about?

A. Yes.

Q. It's painful for them to talk about?

A. That's true.

Q. And clinically there are reasons psychodynamically that they don't want to talk about it?

A. Yes.

Q. And isn't it true victims don't want to admit to themselves they were abused?

A. Yes.

Q. And that's why it's crucial to get collateral information when you're looking at the abuse dynamic?

A. Yes.

Q. I want to show you some material which I'm not sure you've seen yet. These are the three declarations of the Rompilla family, which have already been marked in this [108] case. It's just a few pages. Why don't you take a minute to look at that.

MR. McINTYRE: I'm going to object to the use of these on a couple of grounds. Number one, I don't think these were admitted. Their trial testimony was inconsistent with this. I remember impeaching one of them from it. Why don't you ask him to assume the reports from the family –

MR. WISEMAN: That's one of the ways to do this.

I thought it was generally very consistent, with a couple of minor inconsistencies you may have established.

MR. McINTYRE: I can remember one about some cage. It had turned out that Rompilla was never put in the cage, may not have even seen his brother was put in, as I recall.

MR. WISEMAN: The declaration doesn't say he was in the cage.

MR. McINTYRE: I thought that was included in the declaration. Anyway, it's on the record.

THE WITNESS: Okay.

BY MR. WISEMAN:

Q. Okay. While you were reading that, Mr. McIntyre was having a discussion with me on the record about a cage that was allegedly built.

A. Right.

Q. And the discussion we were having was whether Mr. Rompilla himself was put in the cage or just his [109] siblings. Let me ask you a question about that. In your experience as a clinician dealing with abused families and children and abusers, the dynamic that would lead a parent to build a cage for one child, is it likely in your experience that that would be an isolated incident, or is that more consistent with an abusive profile that would tend to affect all the siblings in the household?

A. No, it's more consistent with an abusive profile.

Q. People don't just build cages for one kid and then treat everybody else fine?

A. Right.

Q. Now, is this the kind of collateral information you'd want to look at, not actually these declarations, but would you want to talk to the people who completed these declarations as a clinician in exploring whether or not there is abuse in a family?

A. Yes.

Q. And these are certainly declarations that evidence severe abuse?

A. Yes.

Q. And these are the kinds of – this is the kind of abuse that would lead to organicity conceivably?

A. Possibly.

Q. And it's the kind of abuse that would lead a child to the type of profile we discussed earlier that abused [110] children have?

A. Yes.

MR. WISEMAN: I'm not sure I'm going to be past 3:00, but I'm going to be a little bit longer than, like, another half hour or so, so maybe we want to take a short break.

MR. McINTYRE: Let's get some lunch.

MR. WISEMAN: Right, but not a long one.

(Thereupon, a luncheon recess was taken.)

* * *

BY MR. WISEMAN:

Q. I think we left off discussing the need to probe very carefully when you're looking at issues related to abuse. I had shown you the family affidavits in this case.

A. That's right.

Q. Now, is there any indication in Dr. Gross' report that he consulted any collateral source about abuse or any other matter?

A. Not that I recall.

Q. Now, with regard to the question of potential head injury, Dr. Gross, as we just discussed, reported that he saw no such evidence or that none was reported to him by Mr. Rompilla?

A. Correct.

Q. Would you agree that just as with abuse, it's [111] important in a forensic setting to probe very carefully in regard to potential traumas to the head when you're looking at neurological issues?

A. Yes.

Q. And would you also agree that it's important not to ask simple, have you ever been hit in the head or have you ever lost consciousness type of questions as opposed to more careful and in depth probing?

A. Yes.

Q. And checking the collateral sources as well?

A. Yes.

Q. In your report, you have a section that discusses the issue of malingering, and you don't actually state any position on it other than to say it's generally something one has to be on the lookout for. There's no indication at all that there's any malingering in any of Mr. Rompilla's 1995 or '96 testing, is there?

A. No.

Q. As long as they're valid and accurate tests as far as you can tell?

A. Yes.

Q. Now, I just want to go over a couple of the achievement tests with you from 1975. Do you still have that in front of you, the transfer petition?

A. Yes.

[112] Q. Now, –

A. The school records or the transfer?

Q. No, these are the D.O.C. transfer petitions, the Wide Range Achievement Test scores. I can give you a copy.

MR. McINTYRE: You have it somewhere, Doctor.

THE WITNESS: Yes, I have it.

BY MR. WISEMAN:

Q. Now, the spelling score and the arithmetic score were in the 4th percentile and 3rd percentile, is that right?

A. Right.

Q. Now, those percentiles in those two areas are consistent with the low scoring that Mr. Rompilla achieved both on achievement tests and on IQ tests when he was a child, aren't they?

A. Correct, yes.

Q. You mentioned, in addition, the 1988 Jastak Wide Range Achievement Tests, where I think you said the D.O.C. record showed he scored in the 1st percentile in reading?

A. Yes.

Q. That also is consistent with the 1975 scores and with the childhood scores, aren't they?

A. Yes.

Q. So would it be fair to say we have a lifelong record in Mr. Rompilla's case of significant [113] underachievement in both IQ testing and achievement testing?

A. That's correct.

MR. McINTYRE: I'm going to object to that. You just asked him for WRAT scores, and now you're asking him about IQ.

MR. WISEMAN: I'll ask them separately.

MR. WISEMAN:

Q. We have a consistent, a consistent lifelong history of cognitive impairments based on both types of scoring?

A. Yes.

Q. So he's been cognitively impaired for as long as he's been tested from childhood all the way up through 1988?

A. Yes.

Q. Does that consistency cause you to feel a little bit – a little more amenable to the dating of the organicity to childhood?

A. Yeah, possibly.

Q. And in that regard, the fact that he scored poorly in 1988, in the 1st percentile in reading –

A. That's consistent, yes.

Q. And it's consistent, and, in effect, it eliminates to some degree the period of 1988 to 1995 as a possible cause for this impairment?

A. Yes.

[114] Q. Now, you looked at the MMPI, and you, based on the scale, called Mr. Rompilla like a raging antisocial person, sociopath, something to that effect?

A. Yes, same thing.

Q. Same thing?

A. The word antisocial personality has now replaced the old term, which is sociopath.

Q. You would agree, would you not, with the – you would agree with the proposition, wouldn't you, that children who suffer abuse often are involved in antisocial behavior?

A. They can be, yes.

Q. So from that perspective, isn't the scoring of a high score on the antisocial scale to some degree consistent with abuse?

A. Yes.

Q. In Mr. Rompilla's case?

A. Yes.

Q. So, again, if you were looking at his MMPI in 1988, either 1975, looking at it in 1988 combining it with the school records, that antisocial score would be further, a further indication to examine abuse as a possible explanation?

A. Yes.

Q. You also stated that some of the differential in [115] the school records between the verbal and the performance indicated a possibility that the low scores might have been a result of his not paying attention. I forgot what you called it, something academically based?

A. Impoverished.

Q. Academic impoverishment. Now, looking at what you know about Mr. Rompilla now, wouldn't you agree that those scores – well, you already said those scores are also consistent with abuse and possible organicity and all the other things we've gone through. Would you say it's more likely than not that the school scores are reflective of an abusive organic child or one who, just because they aren't a very good student, doesn't pay attention?

MR. McINTYRE: Object to the form. You may answer.

BY MR. WISEMAN:

Q. What seems more likely to you at this point?

MR. McINTYRE: Object to the form.

THE WITNESS: Both possibly.

BY MR. WISEMAN:

Q. Both possibly. And, again, the point being that in 1988 you would have wanted to dig deeper to try to sort out that question?

A. Absolutely.

Q. We talked about the Beta exam or you talked about [116] it on direct, the score of 93 in 1975. Do you use the Beta in your work?

A. No.

Q. Do you know of any private clinician who uses it?

A. Yes.

Q. It's used in an institution-type setting where you need to get a large number of people in a –

A. It was originally called the Army Alpha Beta testing. It was used in World War II or World War I.

Q. You don't use it because it's not as reliable as WAIS?

A. Right, and it doesn't give you a subscale scatter.

Q. And that's because it doesn't have a performance portion?

A. Correct.

Q. It just has a verbal?

A. Yes.

Q. So on your direct exam when you said its an alternative to the WAIS, wouldn't it be correct to say it's a poor alternative?

A. Yes. At this point in time, yes.

Q. Now, you were asked who would be in a better position, by Mr. McIntyre that is, to give an opinion as to whether or not Mr. Rompilla fit into any of the statute mitigators in Pennsylvania, and I think you said the doctors [117] in 1988 would be in a better position than the present day physicians or the present day provider, rather?

A. Correct.

Q. Wouldn't you agree that that opinion would be based on an assumption on your part that those folks in 1988 were on the lookout for mitigating evidence? In other words, they were examining Mr. Rompilla to determine if there was mitigation?

A. Yes.

Q. And if I told you that Dr. Gross said in his deposition that he specifically was not looking for mitigation, would you agree that he was not in a particularly good position to find it?

A. Probably.

Q. Okay. And if I were to tell you that Dr. Sadoff in his deposition said that his understanding of mitigation in Pennsylvania is limited only to the two mental health

mitigators as opposed to the catch-all, would you agree that he may have been laboring under a misimpression?

A. Yes.

Q. And what's your understanding of the catch-all indicator in a forensic setting in Pennsylvania?

A. Essentially, it's a question of whether an individual is competent at the time of the act that they're involved.

[118] Q. Okay.

A. Is that what you're referring to?

Q. Well, the mitigating factors that Mr. McIntyre read to you earlier on I refer to as the mental health mitigators, extreme emotional disturbance, inability or lack of capacity to appreciate the criminality of your conduct or to control the criminality.

A. Right.

Q. The eighth mitigating factor in Pennsylvania is the catch-all, anything else about the defendant's background or the commission of the offense that tends to mitigate. That's what we call in the trade the catch-all.

MR. McINTYRE: I'm going to object to your characterization. Why don't we read it, any other evidence of mitigation concerning the character and record of the defendant and the circumstances of his offense.

BY MR. WISEMAN:

Q. Would you agree that abuse, organicity, any of the things we talked about today, wouldn't you agree as a

clinical forensic psychologist that evidence of abuse is mitigating in terms of the catch-all?

A. Yes, it could very well be included, yes.

Q. So in other words, letting a jury know that the person who committed the crime was abused as a child could be mitigating?

[119] A. Yes.

Q. And letting the jury know that that person has organic defects could be mitigating?

A. Yes.

Q. And I guess getting back to Dr. Sadoff, assuming that Dr. Sadoff was not labororing [sic] under that impression, would you agree that he, too, was not in a particularly good position to or not in a better position than Dr. Crown, Dr. Armstrong, to make a call as to whether or not there were mitigating circumstances?

A. I don't know. My understanding, what I know about Dr. Sadoff is he's very thorough. I know he looks at all sides when he does an evaluation. I would be a little hard pressed to say he wasn't in a good position. Again, I can't attest to what his frame of mind was at the time; but knowing him, I know he's very thorough. If he considers it, he'll look for it.

Q. All right. But you would agree, though, that if he was not looking for mitigation related to the catch-all, that the chances that he would identify any were diminished?

A. Possibly, yes.

Q. In terms of all the discussions we've had about the etiology of the organic impairment, we haven't discussed fetal alcohol. I think that's in Dr. Armstrong's report, Dr. Crown's statement, and I think it's mentioned in your [120] report. Would you agree that considering all the uncertainties you may have about dating it and placing it, that fetal alcohol syndrome is also a potential explanation for Mr. Rompilla's deficits?

MR. McINTYRE: Let me place this objection on the record. There is no evidence in this case of fetal alcohol.

BY MR. WISEMAN:

Q. All right. Assuming that there is?

A. Assuming that there is, yes, it's possible.

Q. Now, in regard to your report and a discussion of the EEG, you would agree – well, EEG, the MRI, and the CAT scan, you would agree, Doctor, that EEG's fail to show organicity in a third of the cases. That's a standard statistic?

A. Yes.

Q. And the MRI and a CAT scan will only show so-called hard defects in the brain?

A. Yes.

Q. And by that we mean lesions or tumors?

A. Yes.

Q. So it's quite possible that someone could have a substantial debilitating organic defect, and it would not show up on an MRI?

A. Possibly.

Q. And so we could very well perform an MRI on Mr. [121] Rompilla, and it would eome up negative?

A. Possibly.

Q. But that wouldn't mean he didn't have a defect?

A. Sure.

Q. By the way, was an MRI available in 1988? Were they widely used or used at all?

A. They were just coming into use in the area. I don't particularly recall whether or not one was here. '88, '89, around that time they were here.

Q. Here meaning this area?

A. Yes.

Q. It wasn't like they are now; it wasn't as popularly used, as readily available?

A. Correct.

Q. And, finally, there was some discussion on your direct examination related to brain deterioration due to age. Is the – most people at the age of mid-40's don't have the kind of deficits that Mr. Rompilla has?

A. I hope not.

Q. I think we all concur.

A. No.

Q. It's unusual, his deficit?

A. Extremely.

Q. And in regard to these deficits being caused solely by his incarceration, that also doesn't explain it?

[122] A. That's correct.

MR. WISEMAN: I have no other questions. Thank you, Doctor.

MR. McINTYRE: Just a couple of questions.

REDIRECT EXAMINATION

BY MR. McINTYRE:

Q. You used the word, expression, consistent with throughout your cross-examination by Mr. Wiseman. I take it by consistent with you do not mean causily [sic] related to?

A. No.

Q. All right. Consistent with implies that there could be other causes?

A. Correct.

Q. For that particular condition, correct?

A. Yes.

Q. And I take it you just don't know what those causes are?

A. That's correct.

Q. One other thing, and it's the only other area I have to ask you about, Doctor. Mr. Wiseman asked you a question, he was talking about the WRAT testing being consistent, the grade school WRAT test and the 1988 test,

but then he asked you whether or not the IQ test scores had been consistent. Now, reminding you of the WISC IQ tests from 1957 to '61, which showed basically, I think the first [123] one was 75 verbal, and then it was a 64 total and a 69 total, correct?

A. Yes.

Q. And then the '76 Beta score of 93?

A. Yes.

Q. And then the 1988 WAIS test of 79, are those consistent?

A. Well, when he said consistent, we're talking about different tests. I mean, there were different forms of the test given over a period of time. There is the WISC and then the WISC-R, and you're talking about the Beta, which is completely different. Gross inconsistency would be something fifteen to twenty points out of the range; so for the most part, they are consistent in the sense that they're falling within the same region or area.

Q. But yet they were lower, actually getting into the retarded area, back in the grade school age?

A. Right.

Q. But they weren't in '76 or '88, correct?

A. Correct. Now, typically, the way it goes is that as the – as the tests are revised and improved, the scores tend to get a little lower, okay. So in other words, he would normally have necessarily scored higher on earlier versions of the WISC than later, but it went actually the opposite I think.

[124] Q. Let me ask you this. If it was an organic brain defect causing the low scores back in grade school, wouldn't those scores stay the same throughout his life?

MR. WISEMAN: Objection, assuming that the scores have changed.

MR. McINTYRE: You may answer the question.

THE WITNESS: If you're performing the same test over time, but we've got to account for the variations and the different types of tests that were administered.

BY MR. McINTYRE:

Q. All right. But we have in grade school, we've got them being measured in a retarded area?

A. Yes.

Q. And we don't have that in '76 or '88?

A. Would it have gotten better? No.

Q. And my question to you is if an organic brain defect were causing those scores in a retarded area in a grade school test, how could that ever be corrected over time?

A. It couldn't.

Q. Doesn't that exclude organic brain defect as being the cause of those low scores in the grade school IQ?

A. On that measure, potentionally, yes.

Q. Now, there's other reasons why a grade school child could have low IQ tests?

[125] A. Yes.

Q. Besides brain defects?

A. Maybe emotional issues.

Q. Besides child abuse?

A. Could even had to do with the lack of experience of the examiner. I mean, it depends on who examined him.

Q. This would be my final area, I promise. You were talking about – forget that.

MR. McINTYRE: I have no further questions.

MR. WISEMAN: Just a couple follow-up.

RECROSS EXAMINATION

BY MR. WISEMAN:

Q. The lack of experience of the examiner wouldn't explain low IQ testing over a period of six years?

A. No.

Q. And when you say the scores couldn't be corrected over time, in other words, even assuming that we have scores that were lower in childhood than they were as an adult, Mr. McIntyre asked you if that, in some sense, undercuts the notion or the conclusion that it was organicity as a child, assume you have an organic child in an abusive household, if you take away the abusive household, put the child into adulthood, they might score higher then even though they're organic?

A. Yes.

[126] MR. McINTYRE: No further questions. Thank you. I'm going to attach P-3, 4, 5 and 6.

(Thereupon, the deposition was concluded.)

* * *

[127] I HEREBY CERTIFY that the proceedings are contained fully and accurately in the notes taken by me in the hearing of the above cause, and that this is a correct transcript of the same.

/s/ Robyn L. Berner
ROBYN L. BERNER
REGISTERED PROFESSIONAL
REPORTER